"THE DRUG IS NOT THE PROBLEM": THE PERCEPTIONS OF THOSE WHO HAVE EXPERIENCED SUBSTANCE ADDICTION ON CANADIAN DRUG POLICY

by

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Abstract

In recent years thousands of people have died due to illicit drug overdoses caused by increasingly powerful and contaminated substances offered through the illicit drug market (Corace et al., 2019). The current drug-related overdose crisis has presented an opportunity for drug policy changes throughout Canada. While the current government has made progressive changes to Canadian drug policy in recent years, further research on effective and efficient drug policy is warranted to combat the growing concerns related to the harms associated with drug use and substance addiction.

This study furthers the understanding of how those who have experienced substance addiction view the current and past drug policies in Canada. This research also served to gain this population's insight on the effective and ineffective drug strategies within the system and what approach would best prevent and treat substance addiction. To complete this research, 19 qualitative one-on-one interviews were conducted with individuals who have experienced or are currently experiencing substance addiction.

Several related themes emerged from the interviews, including findings that demonstrate the support among people who have had substance addiction for: the decriminalization of all illicit substances in Canada; a legalized safe supply of specific illicit substances; a rehabilitated and modern approach to treatment programs for substance addiction; and the reduction or elimination of stigmatization towards people who use drugs. The findings of this research add to the growing body of literature that considers the perspectives of those who are addicted to illicit substances – a population that is arguably the most affected by drug policy.

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Dedication

This body of work is dedicated to all those who have been affected by substance addiction, including the thousands of individuals who have lost their lives due to this illness. May we all strive for a future that embraces a compassionate and understanding approach to substance addiction.

Table of Contents

List of Tables

Chapter 1: Introduction

For many, substance addiction is a reality. Either they have struggled with or succumbed to an addiction, or if not themselves, they have watched their mother, father, daughter, son, sister, brother, or friend battling in the trenches of drug use. Those who have experienced this reality live in fear. They fear they will say good-bye for the last time, or never get to say good-bye at all. They fear their loved one will be imprisoned or will be killed. They fear for the damage their loved one may cause to others, or the damage they may cause to themselves. They fear that the latest hit will be the last. This fear is the reality.

Approximately one in five people in Canada will experience substance addiction at some point in their lives (Hoskins, 2019). While substance addiction has always existed and varies in nature, there have been an increasing number of drug-related deaths in recent years – owing to an increase in contaminated illicit substances made available (Corace et al., 2019). Such deaths have brought the issue of addiction to the forefront of Canadian conversation. For example, the Canadian Government has made the opioid epidemic a leading public health and safety concern, and drug-related legislation and strategies have been reformed and implemented. However, as concerns related to the harms associated with drug use and substance addiction grow, the effectiveness and efficiency of these changes need to be examined and future drug policy reform needs to be considered.

Addiction is a complex process in which problematic patterns of substance use or behaviours can interfere with a person's life (Canadian Mental Health Association [CMHA], 2019b). An addiction can be broadly defined as a condition that leads to compulsive and continuous engagement with a stimulus, regardless of negative consequences (CMHA, 2019b; Hartney, 2018). This can result in both physical and psychological dependence on particular

stimuli. Addictions can be either substance-related, such as the problematic use of alcohol or cocaine, or process-related, which includes gambling and internet additions (CMHA, 2019b). While both substance-related and process-related addictions can disrupt an individual's ability to maintain a healthy lifestyle, this research specifically focuses on substance addiction.

Substance addictions under the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) are referred to as substance-related disorders; however, for the purposes of this research, the term substance addiction will be used as it a colloquial term used in Canada (CMHA, 2019b). The DSM-V is based on decades of research and clinical knowledge that recognizes that substance addictions can result from the use of various drugs, such as: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants; tobacco; and other or unknown substances (Hartney, 2018).

The DSM-V also recognizes that not all individuals are equally vulnerable to developing substance addictions, as some individuals are predisposed to a greater likelihood of developing an addiction (Hartney, 2018). Likewise, these substances vary in their potential to be addictive, yet this has little to do with their legal status. For example, tobacco is legal, but it is one of the most addictive drugs on the list. Lastly, this disorder varies in nature and can range from mild to severe depending on specific individual symptoms (CMHA, 2019b; Hartney, 2018).

In its international drug report, the United Nations Office on Drugs and Crime (UNODC; 2018) reported that approximately 275 million people worldwide, which is roughly 5.6% of the global population aged 15 to 64, used illicit drugs at least once during 2016. Of those, 31 million suffered from a substance addiction. Further, the report indicated that approximately 450,000 people died as a result of drug use in 2015, and of those deaths, 167,750 were directly associated

with substance addictions. The report also noted that opioids accounted for 76% of all substance addiction related deaths (UNODC, 2018).

In Canada, while drug trafficking and production have increased in recent years, the overall use of illicit drugs across all age groups has slightly declined (Canadian Centre for Addictions, 2019). Further, from its 2012 Canadian Community Health Survey, Statistics Canada (2015) found that lifetime rates of substance addiction accounted for 21.6% of the sample. The abuse or dependence of alcohol (18.1%), cannabis (6.8%), and other substances (4.0%) accounted for the total lifetime rates of substance addiction in this survey (Statistics Canada, 2015). Thus, it can be inferred that only a small proportion of the Canadian population exhibits substance addictions to illicit drugs, as both alcohol and cannabis are legal in Canada. Despite this, there has been a growing illicit drug overdose epidemic in Canada in recent decades.

Drug overdoses and drug overdose-related deaths have increased substantially in North America since 2000, especially within the past several years (Fischer, Vojtila, & Rehm, 2018; Rudd, Aleshire, Zibbell, & Gladden, 2016; Rudd, Seth, David & Scholl, 2016). In Canada, unintentional drug overdoses have become a public health crisis (Karamouzian, Kuo, Crabtree, & Buxton, in press). The increase in overdoses and drug-related deaths has been linked to the rise in fentanyl and its analogues within the illicit drug market (Corace et al., 2019).[1] Additionally, several other factors have been noted as contributors to the current opioid crisis, including: opioids being prescribed for pain relief; a lack of access to non-pharmacological treatments for pain; a lack of access to evidence-based treatment for opioid use disorder; silos between the mental health and substance use systems; and the stigmatization of people who use drugs (Corace et al., 2019).

[1] Fentanyl is synthetic opioid that is similar to morphine but is 50 to 100 times more potent (National Institute on Drug Abuse, 2019, para. 1).

In 2017, there were almost 4,000 opioid-related deaths in Canada, 1,482 which occurred in British Columbia (BC; Government of Canada, 2018c). Another Canadian report noted that between January 2016 and June 2019, there were more than 13,900 suspected opioid-related deaths (Government of Canada, 2019b). Reported opioid-related hospitalizations occurred more frequently, with 17,050 between January 2016 and March 2019 (Government of Canada, 2019b). Further, in BC, the proportion of illicit drug overdose deaths with detected fentanyl increased from 4% in 2012 to more than 80% in 2017 and 2018 (BC Coroners Service, 2019). Given that BC has been the epicentre of the current drug-related overdose crisis in Canada, in April 2016, BC's Provincial Medical Health Officer declared a public health emergency (BC Centre for Disease Control, 2017). This drug-related overdose crisis has presented an opportunity for drug policy changes throughout Canada.

Historically, Canadian drug policy has been largely based on social and political factors, rather than on scientific research and 'evidence-based' practices (Malleck, 2015).[2] This led to over a century of prohibitionist policy that resulted in an array of adverse outcomes, including high drug overdose rates, high rates of infectious diseases caused by needle-sharing, high rates of incarceration for drug offences, expensive law enforcement costs, and no significant reductions in drug use (Hathaway & Tousaw, 2008). However, the current Canadian Prime Minister (PM) Justin Trudeau and the Liberal Party of Canada have been taking steps since 2015 to reform Canadian drug policy and legislation. To date, they have implemented several progressive policies on drug possession and use, including legalizing cannabis in 2018 (Department of Justice, 2018).

[2] Evidence-based policy is based on scrutiny and assessment of existing research, and the measurement of information about a program or treatment and its subsequent effectiveness (Valentine, 2009).

Moreover, this government has increased its efforts towards researching and implementing evidence-based drug strategies. In particular, the Federal Government has supported the implementation of several harm reduction initiatives across the country. These harm reduction initiatives include: naloxone programs; needle-exchange programs; and supervised injection facilities (SIFs), supervised consumption facilities (SCFs), and overdose prevention sites (OPSs; Government of Canada, 2018b).

Irvine et al. (2019) conducted a study in BC to determine the combined effect of large-scale opioid overdose preventions implemented in BC between April 2016 and December 2017 on the number of deaths averted. They considered the effects of take-home naloxone kits, SCFs, OPSs, and opioid agonist therapy. Irvine et al. (2019) found that between 2900 and 3240 deaths were averted in BC by all interventions combined, with approximately 1580 averted by take-home naloxone kits, 230 by OPSs, and 590 by opioid agonist therapy.

While these initiatives have been effective in reducing various drug-related harms, including fatal overdoses, the rate of drug-related overdose deaths have continued to increase each year (Government of Canada, 2018c; Irvine et al., 2019; Kennedy et al., 2019). Additionally, some have argued that while drugs remain illegal, those who use drugs will continue to be marginalized from society and further criminalized, which decreases the overall effectiveness of the harm reduction strategies (van der Meulen, De Shalit & Ka Hon Chu, 2018; Lavalley, Kastor, Valleriani, & McNeil, 2018). These arguments and the ongoing drug-related deaths have fuelled support for increasingly liberal drug policy in Canada, including discussions on decriminalizing all illicit drugs and providing safe supplies for those who use opioids (Angus Reid Institute, 2019; Corace et al., 2019). Therefore, while the current government has made progressive changes to Canadian drug policy in recent years, it is clear that further research on

effective and efficient drug policy is necessary to combat the growing concerns related to the harms associated with drug use and substance addiction.

To aid in informing future drug policy changes in Canada, several key groups of stakeholders should be involved. In particular, the perceptions of people who have experienced addiction should be considered when developing and implementing drug policy. This includes recognizing the lived experiences of those who use drugs and considering their opinions on the current legislation and subsequent strategies employed by the government to reduce the use of drugs, decrease the harms associated with drug use, and prevent and treat substance addiction.

This research was designed to further the understanding of how those who have experienced substance addiction view the current and past drug policies in Canada. It explores what this population believes are effective and ineffective drug strategies within the system and what approach may be best in preventing and treating substance addiction. The findings of this research add to the growing body of literature that considers the perspectives of those who are addicted to illicit substances – a population that is arguably the most affected by drug policy.

There are several objectives of the current study. First, it examines how the current state of Canadian drug policy affects the various perceptions of those who have experienced or are currently experiencing substance addiction. Second, the study explores the history of Canadian drug policy and its impact on individuals with substance addictions. Third, this research strives to understand the consequences of government mandate changes on drug policy on those who are struggling with substance addictions. Fourth, the project analyzes the perceived effects of punitive versus rehabilitative approaches to preventing and treating substance addictions. Lastly, the project investigates potential options for future drug policy changes that are supported by

those who have experienced or are currently experiencing substance addictions. From these objectives, several themes emerged from the analyzed data, which will later be explored.

Chapter 2: General Problem – The Stigmatization of Drug Use

There is a small but growing body of literature that has examined how individuals who use illicit drugs view current drug policy (Darke & Torok, 2013; Lancaster, Ritter, & Stafford, 2013; Lancaster, Santana, Madden, & Ritter, 2015; Lancaster, Sutherland, & Ritter, 2014). These studies have been recognized as an important step towards considering and incorporating the views of those who use drugs in drug policy analysis, since a majority of public opinion research on drug policy has focused on the perceptions of the general public (Lancaster et al., 2015). Lancaster et al. (2013) contended that policy should be informed by those who use drugs – the individuals it most directly affects. Similarly, Montagne (2002) concluded that there is a need for Canadian research that focuses on the perceptions and experiences of people who use drugs.

Unfortunately, the voices of those who use drugs have often been excluded from drug policy debate – in Canada and worldwide (Lancaster et al., 2013). This has resulted in policy and practices that have excluded the opinions and lived experiences of the specific community it affects (Tutenges, Kolind, & Uhl, 2015). The lack of research on the perceptions of drug using groups is reflected in the policy, prevention, and treatment interventions implemented and has resulted in various ineffective and inefficient drug strategies.

However, critics have argued that individuals who use drugs are too delusional, disorganized, or biased to provide useful information about their own lived experiences. As such, they have argued that this population should be excluded from contributing to drug policy decisions (Tutenges et al., 2015). Regardless of these critical assertions, drug policy should be informed by those who use drugs, since giving this population a voice can better inform policy development and decisions, build trust between this population and the government, and increase the legitimacy of the strategies implemented (Lancaster et al., 2013). Thus, despite the belief

among some individuals that drug policy should not be informed by those who use drugs, there is value in considering and incorporating this population's knowledge and lived experiences into future policy decisions.

Stigmatization and Labelling: Reviewing Goffman, Lemert, and Braithwaite

There are many theories that relate to crime and deviance; however, this analysis will focus on specific theories that aid in explaining how negative societal perceptions of drug using groups affect this population. This negative societal response ultimately lends support to excluding their involvement in policy development. Erving Goffman's (1963) theory of stigmatization outlined the idea of stigma and the plight of those who are stigmatized. He argued that stigmatized individuals are those that are not fully accepted by society and who are constantly striving to adjust their social identities.

Goffman (1963) identified three types of stigma: physical stigma; stigma of group identity; and stigma of character traits. Physical stigma refers to physical deformities of the body, while stigma of group identity refers to stigma that is caused by being a part of a particular race, nation, or religion. Goffman (1963) explained that stigma of character traits are:

> …blemishes of individual character perceived as weak will, domineering or unnatural passions, treacherous and rigid beliefs, and dishonesty, these being inferred from a known record of, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, and radical political behaviour. (p. 14)

Goffman (1963) also argued that the three types of stigma are similar in that they share the same sociological features – an individual who may have been accepted within normal social interactions "possesses a trait that can obtrude itself upon attention", which results in a negative societal reaction and subsequent labelling (p. 15). In other words, an individual who possesses stigma has an undesired differentness from what 'normal' society expects – making that individual an outcast or an 'other' in that particular society.

Goffman (1963) argued that stigma theory is constructed as a way to explain the inferiority of the stigmatized individual, to account for their dangerousness, and to rationalize an animosity based on other differences, such as social class. He suggested that those without stigma, or 'normals', believe that an individual with a stigma is not quite human. Consequently, he maintained that 'normals' exercise multiple forms of discrimination against the stigmatized individual, which effectively reduces their quality of life.

The discrimination against stigmatized individuals leads them to question how others will identify and receive them. He contended that the stigmatized individual's awareness of inferiority leads to self-consciousness, feelings of insecurity, anxiety, and sometimes jealousy (Goffman, 1963). This is referred to as internalized stigma, which is when a stigmatized individual cognitively or emotionally internalizes the negative messages or stereotypes that the greater society places on him or her. Goffman (1963) also asserted that those with similar stigmas, such as alcoholics, sex workers, or people who use drugs, will form small social groups, in which the members of the group all derive from the specific stigmatized category. The individuals who share a particular stigma and social group will subsequently rely on each other for mutual aid or support (Goffman, 1963).

Goffman (1963) explained that there are many signs that can convey social information, and the nature of this information can lead to prestige or to stigmatization. For example, the symbols, or signs, of stigma on an individual can include the scars from an attempted suicide, pock marks or sores from drug use, or the handcuffed wrists of an offender in transit. He argued that due to the visibility of many stigmas, the stigmatized individual will make efforts to conceal their stigma, or to adapt or conform their identity in an effort to be perceived as normal. This allows for some individuals to function with a stigma, while others are outcasted. However,

Goffman (1963) highlighted that there are some individuals, such as sex workers, thieves, and people who use drugs, who must conceal their stigma from one class of persons, such as the police, while simultaneously exposing themselves to other classes of persons, such as clients, fellow-members, and drug dealers. Ultimately, an individual's social identity can affect how they are perceived by others.

Goffman (1963) argued that the term 'deviance' represents the actions of social deviants, a group of stigmatized individuals that consists of sex workers, people who use drugs, delinquents, criminals, jazz musicians, carnival workers, homeless persons, gypsies, alcoholics, show people, full-time gamblers, beach dwellers, and the urban unrepentant poor. He maintained that these individuals are perceived as: failing to use available opportunity for advancement; openly showing disrespect for their superiors; lacking piety; and, representing failures in the motivational schemes of society. Consequently, he affirmed that social deviants collectively deny the social order of normal society. Ultimately, Goffman's (1963) theory of stigmatization concluded that stigmatized individuals are those who are not fully accepted by society, which leads to various forms of discrimination.

Comparatively, Edwin Lemert (1951) hypothesized the notion of primary and secondary deviance. Lemert (1951) argued that the socially visible deviations within a group, community, or society creates a reaction among the whole of the group, community, or society – the nature and severity of the reaction and attitude towards this deviation would depend upon the expectations of the conforming majority. The severity of the societal reaction will depend on the compulsory nature of the norm being violated or deviated from. He explained that the societal reaction will affect the intensity, degree, amount, and visibility of the deviation.

According to Lemert (1951), primary deviance refers to behaviour that does not abide by a social norm yet causes no long-term consequences for the wrongdoer. He noted that the absence of long-term consequences may be due to the fact that the initial deviance prompted no reaction, or that the reaction to the deviance was not particularly negative or stigmatizing. Consequently, primary deviance does not lead to a permanent label from peers, nor to a deviant or stigmatized self-identity.

Lemert (1951) explained that recurring deviations and the formation of a deviant sub-group will work to alter the culture and social organization of the community where the deviations occur. This leads to mythologies, stigma, stereotypes, patterns of exploitation, accommodation, segregation, and methods of control that formalize between the deviants and the rest of society. He suggested that the informal societal reactions are further extended by the formal processes of penalizing and restraining or reforming those who are perceived as deviant. This leads to the status of the individual being redefined as deviant. In this sense, secondary deviance arises when this status is placed on an individual – the permanent status among peers as an outcast.

In essence, Lemert (1951) argued that not all violations of social norms result in long-term negative consequences. Some acts, such as driving over the speed limit, may go undetected by law enforcement or other persons, and result in no consequences. In some cases, the act may be detected, and the perpetrator may be subject to a punishment that serves to deter that individual from further violations, such as being issued a fine for speeding. However, these violations are quickly forgotten, and the perpetrator will proceed with generally law-abiding behaviour. While primary deviance receives no social reaction or mild, corrective action, if deviant behaviour is repeated or persists, the societal reaction becomes stronger and increasingly

punitive (Lemert, 1951). As previously noted, when the continued violations of social norms produce societal consequences strong enough to cause stigmatization, secondary deviance can result.

Lemert (1951) explained that as the individual becomes increasingly reprimanded by society, the individual will begin to resent both the societal norms being violated and the social structures that are imposing the consequences. Eventually the individual will reach a level of resentment that results in the individual creating a self-concept that mirrors the definition of deviant as set by the group. He maintained that the most significant personality changes that occur at this stage manifest when societal definitions become generalized. As a result, the individual is left to define themselves by the greater society, without choice of an alternative role. However, Lemert (1951) also explained that an individual's internal make-up and personality will affect their likelihood of accepting this deviant role, since not all individuals labelled deviant or criminal adopt a criminal role. Those who do accept the deviant social status will make efforts to adjust to their new role, leading to further deviant behaviour.

Essentially, secondary deviance is more severe than primary deviance and results from an entrenched self- and social-identity. Those who display secondary deviance are also more likely to align themselves with others who have been similarly labelled – becoming part of a subculture that rejects the normative framework created by the original social group. In general, Lemert's (1951) theory on primary and secondary deviance sought to explain how labelling and stigmatization affects the deviant nature of those who violate social norms.

John Braithwaite's (1989) theory outlined in *Crime, Shame, and Reintegration* referred to all societal processes of expressing disapproval and evoking remorse in the person being shamed. This theory drew from both Goffman's (1963) theory of stigmatization and Lemert's (1951)

theory on primary and secondary deviance. Goffman's (1963) concepts on shame and stigmatization were used to explain reintegrative and disintegrative shaming, while Lemert's (1951) theory was used in defining a labelling theory. In general, Braithwaite's (1989) theory utilized labelling theory – a theory that posits that some individuals continue to commit crime or engage in deviant acts due to the label that they have been given.

Braithwaite (1989) noted that life circumstances impact interdependency. The most important of these circumstances include individuals who are between the ages of 15 and 25, married, female, and employed, and who have high employment and educational goals. He argued that interdependent persons are more susceptible to shaming, and societies that have increased interdependencies among its citizens are more likely to be communitarian. Braithwaite (1989) identified two types of shaming constructed by interdependency and communitarianism: shaming that is followed by reintegration; and shaming that becomes stigmatization.

Reintegrative shaming is shaming that occurs as an exchange between the injured parties and the perpetrator. This type of shaming is followed by efforts to reintegrate the perpetrator back into the community as a law-abiding and respectable citizen. The efforts of reintegration are often words or gestures of forgiveness or ceremonies to remove the deviant label on the perpetrator. In essence, the act is labelled as evil, while the identity of the perpetrator is labelled as essentially good. Moreover, societies that utilized reintegrative shaming have lower crime rates, due to disapproval being dispensed without stigmatizing labels being instilled (Braithwaite, 1989).

In the second type of shaming, Braithwaite (1989) stated that shaming occurs as part of an individual's stigmatization. He argued that stigmatization is disintegrative shaming, where no effort is made to reconcile the perpetrator with the community. Consequently, the perpetrator

becomes an outcast, with their deviance becoming their master status, or self-identity. In this regard, Braithwaite (1989) drew from the concepts posed by Howard Becker (1963), a labelling theorist who argued that deviant subculture formation partly arose from society's negative reactions to an individual's actions, and the subsequent labelling of the individual. He argued that a negative public label may encourage further deviance, which may lead to criminalization and a 'deviant career'. This is the stage at which the label may become a master status for the outcasted individual, overriding all relationships outside of the deviant group (Becker, 1963).

In the same sense, Braithwaite (1989) maintained the shaming that is stigmatizing increases the attractiveness of criminal subcultures, due to the sense that these subcultures reject the rejecters. Stigmatizing shaming also reduces an individual's interdependencies, such as connections to family and pro-social peers, which increases the individual's attraction to criminal subcultures.[3] Subsequent participation in subculture groups increases interactions with criminal role models and enables training in techniques of crime, which makes the choice to engage in crime more attractive.[4] Thus, just as reintegrative shaming lowers crime rates, when stigmatization is employed, crime rates increase.

It should be recognized that while Braithwaite (1989) drew heavily from labelling theorists, such as Goffman, Lemert, and Becker, his concepts also integrated ideas from social control and social learning theories. Thus, his theory can be categorized as an integrated theory. Ultimately, although this description is only a short summary of Braithwaite's (1989) theory, it helps to explain how shaming and stigmatization can lead to further delinquency.

[3] This idea draws from social control theories, which stipulate that deviance and crime occur due to inadequate constraints; the constraints being positive connections to family, peers, or society.
[4] According to social learning theories, deviance and crime is learned through interactions with close peers. Within these relationships, individuals learn what is and what is not acceptable, based on the reactions of their peers to delinquency.

These theories were reviewed in an effort to connect the stigmatization of people who use drugs to their subsequent discrimination from informing research and policy. Goffman's (1963) theory on stigmatization outlined how individuals become stigmatized based on undesired differences from what 'normal' society expects. Under his theory, people who use drugs are stigmatized based on their character traits – the perception of being weak willed, dishonest, dangerous, and having an unnatural passion. Similarly, Lemert (1951) argued that individuals are stigmatized according to the reactions of a group, community, or society to their 'deviant' characteristic. Differing from Goffman (1963), Lemert (1951) explained that when an excluded and stigmatized individual begins to identify with and display the behaviours of a similarly excluded group, secondary deviance occurs – resulting in ongoing deviance.

However, both Goffman (1963) and Lemert (1951) acknowledged that those who share a stigma will associate with each other. It is evident in that those who use drugs are punished by criminal law and socially excluded from normative society; thus, it is not surprising that these individuals seek the support and companionship from similarly excluded individuals. This can lead to the further stigmatization of these individuals, negative self-perceptions, and continued drug use.

Likewise, Braithwaite's (1989) stigmatized shaming also explained how stigmatization leads to increased or continued drug use among those with substance addiction. Braithwaite (1989) differed from Goffman (1963) and Lemert (1951) in that he considered both positive shaming, which is reintegrative shaming, and negative shaming, such as disintegrative, or stigmatized, shaming. According to this theory, criminalizing and increasing punitive measures against people who use drugs, with no options for healthy reintegration into society, will only exacerbate their situations. That being said, laws and penalties meant to deter people who use

drugs from consuming illicit drugs will only be successful if there are positive supports or reintegrative options for the them to return to society in a positive way; if these supports are lacking, harsh laws and penalties will only further stigmatize and criminally entrench these individuals. Thus, according to this theory, traditional 'tough-on-crime' approaches will not be successful in reducing illicit drug use, due to the lack of options offered for healthy reintegration into society.

Overall, these three theories can be combined to explain how those who use drugs are stigmatized and why they have been rejected from the drug policy debate. First, Goffman (1963) explained the societal reaction to those who use drugs problematically, and their subsequent social stigmatization. Second, Lemert's (1951) concepts supported the criminalization process of these individuals, by illustrating how societal reactions to drug use have led to the stigmatization and the penalization under law of these individuals – leading to further drug use by the individual. The stigmatization of those who use drugs has subsequently resulted in this population being excluded from the policy debate. Lastly, Braithwaite's (1989) theory lends the idea that positive shaming can be successfully applied to deviant actions; however, for shaming to occur without the outcome of stigmatization, positive supports or reintegrative options need to be offered. From this, it can be concluded that harsh laws, penalties, and stigmatization, will only exacerbate the current drug epidemic; yet positive reintegrative action may ultimately reduce the number of those with substance addiction.

It is clear that the stigmatization of particular individuals often leads to further deviance. Moreover, as Goffman (1963) suggested, individuals with a stigma, including those who use drugs, are perceived by 'normals' as not quite human. This perception decreases the perceived value of this populations' knowledge and lived experiences that could help inform drug policy.

Additionally, it could be argued that the continued discrimination of this population has negatively impacted their ability to contribute to policy development. Nonetheless, acknowledging the lived experiences and knowledge of those who have experienced drug use and addiction is the first step to reducing the current stigma against this population.

The Dirty and the Dangerous: The Ugly Reality of Stigma

Several researchers have indicated that the stigmatization of those who use drugs and people who inject drugs has contributed to the lack of research exploring this community's views on drug policy (Lancaster et al., 2014; Lloyd, 2013; Tutenges et al., 2015).[5] Tutenges et al. (2015) explained people who use drugs are often written and spoken about, yet this community is rarely given the chance to speak for themselves. They argued that this trend has resulted in a negative perception that vulnerable populations, such as those who use drugs, are too delusional to provide useful information about their experiences. Furthermore, people who use drugs are often stereotyped as homeless, unemployed, unclean, or dangerous (Australian Injecting and Illicit Drug Users League [AIVL], 2011; Lancaster et al., 2014). Thus, it is important to understand the current research literature on the stigmatization of people who use drugs.

AIVL (2011) reasoned that the criminalization of drugs and drug use is a direct result of stigma. They argued that the criminalization of this population negatively affects their health and wellbeing. This is due to the barriers to health care and other resources that arise when stigmatization and discrimination occur. Additionally, the report maintained that very few people who use drugs are able to overcome being labelled a 'drug user', as terms such as 'rehabilitated

[5] Stigmatization is described as a negative stereotype which results in the discrimination and ostracism of a particular group or members of society (Australian Injecting and Illicit Drug Users League [AIVL], 2011). Stigmatization has always been a part of human society and while the stigmatized group may change over time, there is always a group or groups that are viewed negatively based their behaviour (AIVL, 2011). In recent years, the term 'stigma' has been increasingly associated with the discriminatory and prejudicial treatment of minority groups, such as individuals who are disabled or mentally ill (Lloyd, 2013).

drug user', 'treatment user', 'criminal user', and 'ex-user' are still used to identify those who may have recovered from their addiction. Those who are able to transcend the status of a 'user' are often still associated with the drug using community as guest speakers, research subjects, or peer support (AIVL, 2001).

Likewise, Lloyd (2013) found several themes regarding the stigmatization of people who use drugs. Lloyd (2013) concluded that the stigma associated with problematic drug use reflects wider public fears about illicit drug use in general. He argued that the rationale behind the fear of illicit drugs is complex but is often derived from the social history of the drugs, negative media attention, political rhetoric, and the fact that many illicit drugs are unfamiliar and poorly understood by the general population. Lloyd (2013) also noted specific stigmas that revolve around public conceptions of the 'junkie' or 'addict'. A key aspect of this stigma is the injection of illicit drugs, as this was perceived by many as 'dirty'. Additionally, Lloyd (2013) found that those addicted to drugs are perceived as dangerous and desperate – willing to commit crimes or odious acts to support their addiction.

Moreover, the literature revealed that blame and personal responsibility often characterize the general population's attitude towards this group of individuals. Lloyd (2013) reported that individuals with substance addiction are often blamed for their condition due to the misconception that they chose to use drugs. Thus, this group is viewed as having the personal responsibility to quit using illicit drugs.[6] Similarly, Corrigan, Kuwabara, and O'Shaughnessy (2009) found that individuals addicted to drugs were viewed as significantly more responsible for their disorder than people with mental illness or physical disabilities. People who use drugs

[6] Research on substance addiction has indicated that addiction is linked to genetic, psychological, and social factors, which helps to reduce the stigma of blame against people who use drugs and further challenges the idea that ceasing to use drugs is simply a matter of self-will (Lloyd, 2013). Despite this, the stigmatization of drug use continues within many societies.

were also viewed as substantially more dangerous and fear-evoking (Corrigan et al., 2009). The findings from these studies illustrated the stigmatization of people with substance addiction and demonstrated how discrimination results from such stereotypes and stigma.

Peretti-Watel (2003) studied the public opinions and attitudes toward drug issues in France. They concluded that the stigmatization of those who use heroin is an obstacle to risk reduction policies. That being said, a minority of the participants endorsed a stereotyped perception of this population, viewing this group as 'folk devils' or people who are dangerous, have no will of their own, and corrupt young individuals (Peretti-Watel, 2003). Furthermore, a majority of the participants considered people who use heroin as dangerous towards their family and friends. These stigmatizing views were found to affect policy decisions on substance addiction and drug use.

To further this understanding, Lancaster et al. (2015) presented people who inject drugs with the survey results of a previous study (see Lancaster et al., 2013) and asked them to interpret and discuss the results (Lancaster et al., 2015). Lancaster et al. (2015) found that the participants' interpretations of the data were largely informed by the negative stereotypes of people who use drugs. For example, Lancaster et al. (2015) found that the participants unanimously agreed that needle and syringe programs were an important public health intervention, yet the results of the previous study indicated that some of those who use drugs did not support this intervention. The participants explained that their views could have reflected their internalized stigma about their own drug use – a perspective of shame (Lancaster et al., 2015).

The participants also explained why their peers were not universally supportive of drug law reform. They suggested that certain sub-groups of people who use drugs and specific drug

types are often perceived as being worse or more dangerous than others, leading to within-group stigma. The participants also explained that certain substances, like methamphetamine, are perceived as more dangerous, while those who used heroin generally faced more discrimination than other sub-group populations (Lancaster et al., 2015). Within-group stigma occurs when a marginalized group, such as those who inhale drugs, stigmatize or discriminate against another similarly marginalized group, such as those who inject drugs. This type of stigma can also be called horizontal stigma. Overall, this study found that people who use drugs' own internalized stigma can negatively affect their interpretations of drug use and drug law reform, and can also lead to within-group, or horizontal, stigma.

Similarly, Radcliffe and Stevens (2008) conducted qualitative interviews with people who use drugs and found that they both recognized their own lived experiences of drug use and viewed the existence of junkies as an 'other' or someone to be rejected. Many also indicated that their experiences of drug treatment were stigmatizing. They reported that their own self-identities became tainted upon contact with the drug treatment facilities due to being viewed as a junkie or an addict. This view was particularly prominent among several groups of people who use drugs, including females, young people, and those who misuse prescription drugs and cannabis (Radcliffe & Stevens, 2008). In effect, several of the participants indicated that the fear of being seen using drug treatment services was a barrier to continuing treatment.

Overall, it is evident that there are highly stigmatizing views towards people who use drugs and between sub-groups of those who use drugs. Moreover, it is clear that the internalization of these stigmatizing perceptions has affected this population. Nevertheless, the stigmatization of people who use drugs has continued to silence this population. This has resulted in limited research that addresses the perceptions of those who have experienced

substance addiction and has hindered the development of consumer-informed policy, prevention, and treatment interventions (Tutenges at al., 2015). In effect, various ill-informed and ill-prepared drug strategies have been implemented by policy makers, who were eager to show initiative and social responsibility yet lacked a clear understanding of the people that the policies were meant to benefit (Tutenges et al., 2015).

The review of the literature on the stigmatization of people who use drugs was critical in the development of the current project for several reasons. First, the findings demonstrated how drug use is characterized as deviant, consequently leading to further discrimination and stereotyping. This parallels the conclusions drawn from the theories presented. As a result, such barriers exclude people who use drugs from partaking in research and informing drug policy.

Second, the connection between the theories and the research helped to explain why there is limited research focusing on the perceptions of those who use drugs. The stigmatization of this population has contributed to their exclusion from research. People who use drugs have been perceived as too delusional to provide useful information about their own lives and situations. Furthermore, they are often labelled as deviant and stigmatized as homeless, unemployed, unclean, or dangerous. These misconceptions have resulted in an overall lack of understanding of this population's acute needs. Accordingly, there has been an over-reliance on biased and misinformed research to inform drug policies. This is an important discovery that is rationalized by both the theories and literature reviewed. Consequently, the research on the stigmatization of people who use drugs defends the need for more inclusive and comprehensive drug policy research.

Third, this review allowed for a better understanding of the current findings. In other words, considering the stigmatization of this population led to a better appreciation of the

participant's responses in the current project. That being said, the studies aided in the discussion of this project's findings, particularly regarding the issue of stigmatization in Chapter 6. Ultimately, this review was necessary to understand the foundation of the current research. Fortunately, in recent years, academics have increasingly acknowledged the importance of people who use drugs' perceptions. As a result, there has been a growing body of literature that analyzes the perceptions of those who use drugs, which will be explored below.

Chapter 3: Review of the Relevant Sources

Literature Review

Drug Laws: A User Perspective

A number of studies on the perceptions of those who use drugs have focused on their views of either drug policy or drug strategies. For example, Greer and Ritter (2019) conducted a qualitative investigation with 37 participants on their opinions regarding drug laws and how they think drug laws could be improved. Results from this study indicated that decriminalization, legalization, and a medical or prescription model were all common preferences.

The most supported model for drug reform was drug regulation through the medical system. Greer and Ritter (2019) noted that support for this model was largely based on its perceived helpfulness. The researchers also found that while many of the participants supported drug law reform, they shared the view that drug laws were unlikely to change. Moreover, the participants argued that a change in public opinion is necessary for any vital drug law reform to be successful (Greer & Ritter, 2019). Essentially, the participants supported drug law reform in Australia, yet were sceptical of these reforms occurring.

Greer and Ritter (2020) furthered the discussion on the government's role in regulating a legal market and why participants were sceptical of this approach. Some of the concerns related to the personal agency of people who use drugs under a medically regulated drug supply model. The researchers explained that the concerns stemmed from the participants' lack of trust in the government, and their belief that the government is corrupt. Additionally, some of the participants argued that the government had vested interests in maintaining prohibition, as it creates jobs throughout the criminal justice system. Others believed that the government would

only support regulation of drug use to increase their own monetary profits from drug-related revenues (Greer & Ritter, 2020).

The participants discussed both the potential harms and benefits of legalizing and medically regulating a drug supply. Potential harms included an increase in use and experimentation from those who otherwise would not have tried drugs. On the other hand, perceived benefits included an increase in the quality and the safety of drug supplies (Greer & Ritter, 2020). Ultimately, these findings suggested that while drug regulation through the medical system was supported by the participants, there were still concerns regarding this drug reform model.

In Australia, Darke and Torok (2013) interviewed persons who inject drugs to learn their perspective on the legal status and perceived harms of five illicit drugs, including: heroin; methamphetamine; cocaine; 3,4-Methylenedioxymethamphetamine (MDMA); and cannabis. The researchers found that people who inject drugs viewed different drug types distinctively, with perceptions being related to their own drug use history. A majority of respondents supported legalizing cannabis, and there was modal support for the decriminalization of heroin. However, Darke and Torok (2013) found that this population did not favour legal changes for methamphetamine, cocaine, and MDMA. In terms of associated harm, methamphetamine was rated by participants as the most harmful, followed by cocaine, MDMA, heroin, and cannabis (Darke and Torok, 2013). Ultimately, lower levels of perceived harm led to increased support for the legalization of all substances and the decriminalization of heroin.

In another Australian study, Lancaster et al. (2014) assessed the opinions people who use drugs on Australian drug policy and its subsequent strategies. They used survey information from the 2012 Ecstasy and Related Drugs Reporting System (EDRS) and the 2011 Illicit Drug

Reporting System (IDRS).[7] Lancaster et al. (2014) found that support for legalizing cannabis was expressed strongly by both the IDRS and EDRS participants. However, while 44.3% of the EDRS participants supported the legalization of MDMA, only 24.9% of the IDRS participants did. As well, 54.9% of the IDRS participants supported the legalization of heroin, whereas only 12.8% of the EDRS participants shared this support (Lancaster et al., 2014). Furthermore, 75.5% of the EDRS participants opposed the legalization of heroin, yet only 33.1% of the IDRS participants responded similarly. Ultimately, with the exception of support for the legalization of MDMA, a greater proportion of IDRS participants supported legalization for the personal use of each drug (Lancaster et al., 2014).

Lancaster et al. (2014) also measured and compared the support for strategies to reduce the harms associated with heroin use. They noted significant differences in reported levels of support for all harm reduction and treatment interventions between the IDRS and EDRS participants. While 96.6% of IDRS and 83.6% of EDRS participants supported needle and syringe programs, and 80.5% of IDRS and 63.3% of EDRS participants supported regulated injecting rooms, opinions differed in regard to treatment inventions (Lancaster et al., 2014). Moreover, Lancaster et al. (2014) reported that IDRS participants were more supportive of methadone and buprenorphine maintenance treatment and rapid detoxification therapy than the EDRS participants.

The most notable differences were observed in responses to the trial of prescribed heroin, as 74.6% of IDRS participants supported the implementation of prescribed heroin, while only 30.6% of EDRS participants shared this support (Lancaster et al., 2014). Furthermore, 33.4% of

[7] The EDRS is used to monitor the ever-evolving patterns of drug use among those who regularly use MDMA and psychostimulants, such as cocaine and methamphetamine, as well as examines drug prices, purity, and perceived availability (Lancaster et al., 2014). Comparatively, the IDRS monitors patterns of use and drug market trends among people who inject drugs.

EDRS participants opposed this trial in Australia, compared to 13.1% of IDRS participants (Lancaster et al., 2014). Ultimately, the findings of this study show that the views on drug policy interventions in Australia vary significantly between people who inject drugs and those who regularly use MDMA.

To further their understanding, Lancaster et al. (2015) conducted three qualitative focus groups in Australia with participants who had a history of injection drug use. The participants were presented with the survey results from the 2011 IDRS (see Lancaster et al., 2013) and were asked to discuss whether they supported or opposed each policy item. The discussions served to elicit participants' interpretations of the survey findings. The researchers found that the participants' opinions and interpretations of the quantitative data was largely based on an amalgamation of the participants' opinions, knowledge, and lived experiences. They noted that their peers might not have been universally supportive of drug law reform due to differences in their preferred drug type, and their perception of the harms caused by each drug. Moreover, the participants wished for more non-punitive and non-discriminatory treatment opportunities. Evidently, there are differences in opinions on drug policy within different populations of people who use drugs (Lancaster et al., 2015). Therefore, these findings speak to the diversity of attitudes and experiences within the drug using population.

The Good, the Bad, and the Ugly: Thoughts on Drug Strategies

Many research studies have also explored the perceptions those who use drugs on general and specific drug strategies, which include methadone maintenance programs and harm reduction initiatives. Lancaster et al. (2013) found that respondents who used drugs strongly supported needle and syringe programs (96.8%), methadone and buprenorphine maintenance programs (86.3%), drug treatment either than methadone (82.7%), regulated injecting rooms

(80.5%), and a trial of prescribed heroin (74.6%). Additionally, in their comparison of drug using groups, Lancaster et al. (2014) found that both the IDRS and EDRS groups supported harm reduction measures, such as needle and syringe programs and regulated injection rooms. Evidently, harm reduction strategies are supported among many of those who use substances.

Several studies examined the general perceptions of those who use illicit drugs on various service providers. For example, Neale (1998) conducted interviews with people who use drugs in England to understand views on drug service providers, such as: specialist drug agencies; counsellors; general practitioners; pharmacists and pharmacy staff; needle exchanges; detoxification and rehabilitation units; self-help groups; and criminal justice agencies. Participants commented positively on the specialist knowledge of staff, the availability of advice and help, the provision of a wide range of facilities, and staff being accessible, willing to listen and having a good attitude (Neale, 1998). The participants noted that negative attributes of service providers included: frequent staff changes; lack of knowledge; workers trying to take control, or being dishonest, about the range of treatment options; inconsistent prescribing policies; strict appointment times; stereotyping; and not trusting the clients.

Additionally, Neale (1998) found gender differences in drug service utilization. Men were more likely than women to use specialist services, such as needle exchanges, detoxification units, and self-help groups. Comparatively, women were more likely than men to use generic services, such as those provided by doctors and pharmacists, drug counsellors, and written material. Lastly, Neale (1998) found that women were more likely than men to report dissatisfaction with the services provided for those who use drugs.

Over a decade later, Neale et al. (2015) conducted five focus group interviews in England. A majority of the participants felt that many of the service providers expected too much

from the service users. Furthermore, in all the focus groups, participants reported frustration with service providers who failed to consider the complex needs and vulnerable circumstances of each individual. For example, Neale et al. (2015) noted that many argued that the seemingly positive goals for their recovery could have negative consequences on their lives, such as over-confidence, stress from the pressure to gain employment, constant self-reflection that prevents closure, and avoiding people to prevent relapse. These consequences serve to show the complex needs and vulnerable circumstances of each individual struggling with addiction. Overall, Neale et al. (2015) concluded that given the participants' experience with such programs, they could provide valuable insight into the perceptions of service providers.

In a similar study, Kolind (2007) used semi-structured interviews with the consumers of the Danish Methadone Project, in order to gain their perspective on the advantages and limitations of this program. The Methadone Project varied from the standard methadone treatment program in several ways. The program featured a reduced client-counsellor ratio, and frequent and accessible individual counselling. Moreover, the program's drop-in centers were open more than three hours a day and included health-related services. Lastly, the program experimented with methadone dispensing, such as intravenous methadone and individual face-to-face flexible dispensing. Those who utilized this program found that the attitudes of their counsellors were positive and attentive, and they commented positively on the accessibility of spontaneous counselling and the spaces that facilitated non-stigmatizing social encounters (Kolind, 2007).

While the Danish Methadone Project received positive feedback, Fischer, Chin, Kuo, Kirst, and Vlahov (2002) found less supportive views in their Canadian-based study. Fischer et al. (2002) conducted focus groups with individuals who use opioids in Canada's three largest

cities – Toronto, Montreal, and Vancouver. This study examined participant views on methadone and other opiate prescription treatment. The study found that many perceived it to be punitive and controlling, pervasively regimented, and disempowering. Moreover, the majority of participants felt that methadone was harmful to the body, citing negative side effects, such as back-aches, constipation, sweating, body aches, weight gain, headaches, nausea, sleepiness, loss of sex drive, numbness, and seizures (Fischer et al., 2002).

Furthermore, many of the participants who had been on a methadone treatment program believed that methadone was more addictive than heroin. The participants noted that the structure of the methadone program limited their ability to work, travel, and socialize. Moreover, many perceived the treatment providers and staff to be 'out of touch' with the clients' experiences, disinterested, and profit driven. Comparatively, those who positively viewed the methadone treatment programs noted its benefits in helping them reach sobriety, reducing their need to commit crimes to support their addiction, providing structure and stability in their lives, and being cheaper, more accessible, and more reliable than heroin (Fischer et al., 2002).

Fischer et al. (2002) also noted that the participants had divergent beliefs of what constituted an ideal treatment program. While some believed that the ideal treatment would be a program that prioritizes detox and abstinence-based treatment programs, others believed that an ideal program would focus more on harm reduction. Regardless, all participants strongly expressed the need for choice and freedom in both the design and course of their treatment (Fischer et al., 2002).

Interestingly, Fischer et al. (2002) found that although participants supported the idea of having a prescription heroin program available, opinions regarding the eligibility criteria, structure, and objectives varied (Fischer et al., 2002). Many of the participants agreed that heroin

prescription programs should be highly regulated and supervised. Some positive benefits of implementing a heroin prescription program included: a reduction in drug-related crime; a reduction in the use of other substances; and increased stabilization (Fischer et al., 2002).

Similarly, in Montagne's (2002) study on the perceptions of Canadians who use opioids on methadone maintenance programs, a majority of the respondents indicated that they would prefer heroin maintenance, while 18.0% preferred buprenorphine, and the other treatments were chosen by 5.0% or less of the respondents. These studies demonstrated the difference in perceptions and experiences between those who participate in methadone treatment and those who offer this treatment, develop policy, or research addiction and pharmacotherapies (Fischer et al., 2002; Montagne, 2002).

Lutnick, Case, and Kral (2012) presented another study that considered the views of the consumer group on a specific drug strategy. Lutnick et al. (2012) completed semi-structured interviews on people who inject drugs in San Francisco, California, to assess their perceptions on increasing services for them within pharmacies. While many of the participants welcomed more services for people who inject drugs, they voiced concerns with the implementation of such services in pharmacies. Many reported negative experiences resulting in the perception of pharmacists and pharmacy staff as judgemental and unhelpful. Additionally, none of the 11 participants had been offered information by pharmacy staff about testing services, HIV risk reduction, or drug treatment services (Lutnick et al., 2012). Further, in discussing syringe exchange programs in pharmacies, many voiced concerns with privacy and accessibility and noted that they feel more comfortable receiving services from community clinics. Overall, while the participants noted some benefits to expanding services in pharmacies, issues of privacy and negative experiences with pharmacists and pharmacy staff were most concerning.

The previous studies have helped shed light on the various views on effective and efficient addiction related services and service providers. All participants strongly expressed the need for choice and freedom in the design and the course of their treatment (Fischer et al., 2002). Moreover, many of the participants expressed frustration with service providers (Neale et al., 2015). These findings demonstrate the importance of incorporating the views of people who use drugs when creating and implementing drug strategies.

It all Comes Down to This: A Summary of the Literature

Many studies on the perceptions of those who use drugs have focused on their views of either drug policy and legislation or drug strategies, such as methadone programs or harm reduction initiatives. The findings highlight the diversity of attitudes and experiences among people who use drugs. For example, it was reported that those who use drugs have different opinions on what constitutes an effective and efficient addiction related service and service provider. Despite the differences, many participants strongly expressed the desire for choice and freedom in the design and course of their treatment.

After reviewing the literature in this area, it is clear that there is tension between the opinions and lived experiences of this population and the reality of the policies and practices implemented. Although it is clear that those who use drugs have varying views, their opinions are critical in contributing to the implementation of effective and efficient drug policies and strategies. These opinions should be considered an important step in creating an ethically sound approach to drug treatment (Kolind, 2007).

Canadian Drug Policy: The Evolution

The criminalization of certain drugs under Canadian law is fairly recent. Laws prohibiting the use of cannabis, heroin, cocaine, and other substances were first passed in the

early 1900s and were criticized for relying heavily on the social, cultural, and moral contexts of the time (Malleck, 2015; Toronto Public Health [TPH], 2018). As such, academics have argued that certain substances were first prohibited due to their status as a *public* health risk (MacKay, 2018). In other words, they have maintained that the government prohibited these substances based on their potential harms to society, while only marginally considering their potential health risks. Thus, the motivation to implement these early laws were largely motivated by social ideals and control (MacKay, 2018). This ideology led to over a century of prohibitionist drug policies in Canada that have relied on criminal law to control drug supplies and to punish those in possession of illicit substances (Erickson, 1992).

Since 2015, Canadian Prime Minister (PM) Justin Trudeau and the Liberal Party have worked to reform Canadian drug policy and legislation. They implemented several policies on drug possession and use, including the legalization of cannabis in 2018 (Department of Justice, 2018). Moreover, this government increased its efforts towards researching and implementing 'evidence-based' drug strategies. The implementation of these strategies, such as take-home naloxone kits, OPSs, and opioid agonist therapy, has been successful in preventing many drug-related deaths in Canada in recent years (Irvine et al., 2019).

While these initiatives are effective in reducing various drug-related harms, including fatal overdoses, the rates of drug-related overdose deaths have continued to increase each year. This increase is related to the rise in fentanyl and other high powered opioid contaminated drugs (Government of Canada, 2018c; Fischer, Vojtila, & Rehm, 2018; Irvine et al., 2019; Kennedy et al., 2019). In an effort to better understand the implications of these recent changes, and to appreciate the results and recommendations of this research, it is necessary to analyze the history of Canadian drug policy.

Moral Panics and Racism: The Beginning of Drug Prohibition

The first legal framework of drug control in Canada was introduced in 1908, with the implementation of the *Opium Act* (MacKay, 2018; Riley, 1998). While regulations on all medicines, tobacco, and alcohol were introduced at this time, the *Opium Act* was the first Canadian document that prohibited a drug (Riley, 1998). The *Opium Act* specifically prohibited the importation, manufacture, and sale of Opium for non-medical purposes, as well as imposed criminal penalties for using and trafficking this substance (MacKay, 2018; Malleck, 2015).

Scholars have argued that the *Opium Act* emerged directly from racial violence (Malleck, 1997). In 1907, there were rumours that Japanese labourers were set to arrive in Vancouver, causing white residents to riot through Vancouver's Chinatown. Deputy Minister of Labour William Lyon Mackenzie King was dispatched by the Federal Government to Vancouver. King considered the damages to Japanese and Chinese businesses, and recommended reparation payments (Malleck, 1997). King received applications for damages to two opium manufacturers. These applications led a review of opium smoking in the city, which resulted in the recommendation to prohibit the substance (Malleck, 1997).[8] The *Opium Act* was subsequently passed through the House of Commons with little discussion.

In 1911, the *Opium Act* was replaced by the *Opium and Narcotic Drug Act* (ONDA), which prohibited the use of other opioids, such as morphine, and cocaine (Riley, 1998). The ONDA also added harsher penalties, such as imprisonment, for individuals caught using the prohibited substances (TPH, 2018). In 1922, the ONDA was amended to include the penalty of deportation for immigrant offenders. Amendments also stipulated that those charged under this act were considered guilty until proven innocent (Hewitt, 2004). Further, in 1923 cannabis was

[8] Scholars have argued that King's motives were based on regulating the behaviour of the Chinese labourers, a group that was gaining upward mobility in BC through the sale opium (Malleck, 1997).

added to the list of prohibited substances (Riley, 1998). The ONDA remained in effect until 1961 (TPH, 2018).

Early Canadian drug policy was most notably influenced by the strong moralistic values and the Eurocentric and racist attitudes of society (Gordon, 2006; MacKay, 2018). Before 1908, many Canadians opposed the consumption of drugs and alcohol, as they believed these would negatively affect the morality of the consumer (MacKay, 2018). Organizations, such as the Women's Christian Temperance Union, ardently encouraged abstaining from drugs and alcohol as a means to improve personal health and religious morality. These moralistic values permeated Euro-Canadian society in the early twentieth century, which largely influenced the creation of law and policy (MacKay, 2018).

Moreover, in the late 1800s and early 1900s, Canadian society was openly hostile towards immigrants who were deemed inassimilable, in particular those of Chinese heritage (Hewitt, 2001; Malleck, 1997). These racist ideologies were prominent in popular literature, which affected policy development. Emily Murphy's *The Black Candle* outlined the evils of the drug trade. [9] The sentiments shared by Murphy (1922) were focused on the dangers of opium, cocaine, and cannabis. Murphy (1922) blamed the Canadian immigrant population for the supply and sale of these substances – specifically focusing on the Chinese immigrant population when discussing opium. Murphy's (1922) work is argued to have contributed to the amendments made to the ONDA in 1922 and 1923 (Jackel, Cavanaugh, & Marshall, 2019).

The popular rhetoric on opium and its criminalization was underpinned by anti-Chinese sentiments, and Chinese-Canadians were heavily affected by the imposed legislation (Gordon, 2006; Hewitt, 2004). For example, between 1923 and 1932, nearly two percent of the Chinese

[9] Murphy was a Canadian author, women's right activist, and judge.

population in Canada were deported under the ONDA, and in 1922 alone, nearly three percent of this population were convicted (Hewitt, 2004). Similar to the criminalization of opium, the use of both cannabis and cocaine were widely viewed as drugs used by the non-Euro-Canadian 'other' and were prohibited. This ideology mirrored the United States (US), who strictly prohibited the use of cannabis and crack-cocaine since those of Hispanic and African descent were viewed as using these substances. Overall, early Canadian drug policy was largely affected by the views and attitudes of society, which resulted in the prohibition and criminalization of various substances (Gordon, 2006).

While the ONDA prohibited and criminalized several substances, there were no provisions in the act for the treatment of addictions (Hewitt, 2004). Specifically, in 1923, the Federal Minister of Health acknowledged that the government had failed to support addiction treatment, as it was considered a provincial responsibility (Hewitt, 2004). Further, in 1933, a Member of Parliament questioned the availability of funding for the treatment of substance addictions. It was reported that there was no funding available and that addiction treatment was a Provincial responsibility (Hewitt, 2004). As such, the Federal Government's first response to substance use was to treat it as a criminal problem; thus, federal money was distributed among law enforcement agencies and correctional facilities, rather than for treatment (Hewitt, 2004).

It is important to understand the history of Canadian drug policy, as these laws and strategies deeply affect current Canadian policy on illicit substances. The earliest of drug policies in Canada were based on moralistic attitudes and racist ideals, with little regard for empirical research or scientific thought – let alone the opinions and insights of the people that they sought to criminalize. Subsequently, the prohibitionist foundation of these policies has been the basis of the laws and strategies on drugs developed in Canada. Thus, it is not surprising that these

policies have continued to be ineffective and inefficient in addressing substance use and addiction. Unfortunately, a reliance on this prohibitionist foundation has continued throughout the past century.

Changes in the 1960s and 1970s: Groovy or Far Out?

While Canadian drug policy and legislation changed in 1961, these modifications reinforced the division between licit and illicit drugs. The United Nations (UN) codified international drug prohibition and regulation through the *Single Convention on Narcotic Drugs* and the *Convention on Psychotropic Substances*, both of which Canada is a signatory (UN, 1961 & 1971). The Canadian Government passed the *Narcotic Control Act* (NCA) in 1961 to implement the provisions that were outlined in the *Single Convention on Narcotic Drugs*. The substances referred to as 'narcotics' under the NCA included heroin, cocaine, and cannabis (Canadian Foundation for Drug Policy [CFDP], 2001). Under the NCA, the possession of a narcotic substance was prohibited, with a penalty of up to seven years imprisonment. Moreover, possession for the purpose of trafficking, and trafficking, cultivating, importing, and exporting were all heavily penalized (CFDP, 2001).

Despite the provisions against illicit drug use under the NCA, the use of substances, such as cannabis, lysergic acid diethylamide (LSD), and cocaine, were popular among youth in the 1960s and 1970s (Marquis, 2005). This led to a moral panic among older generations (Marquis, 2005). Further, the increased use of substances among youth pressured the Federal Government to consider liberalizing its drug laws, as the court system was becoming inundated with a rising number of youth sentenced with drug offences (Riley, 1998). Canadian drug policy followed the pattern in the US – as the impetus to change drug laws occurred suddenly when middle- and upper-class Caucasian youth became heavily involved in the system.

In 1969, in response to growing social and political concerns, the Federal Government, under PM Pierre Trudeau, formed the *Commission of Inquiry into the Non-Medical Use of Drugs*, which is popularly referred to as the Le Dain Commission (Marquis, 2005). This commission concluded that drug prohibition resulted in high social, political, and economical costs (Le Dain, 1973). As such, a less punitive approach was recommended to discourage the use of illicit substances and reduce harm. This included a gradual withdrawal from criminal sanctions against drug use, particularly for the use of cannabis (Le Dain, 1973).

The conclusions of this Commission were ignored by the Federal Government; however, an amendment was made to the NCA in 1969 allowing prosecutors to proceed summarily in possession cases, resulting in fewer penalties for drug use. Further, the *Canadian Criminal Code* was amended in the early 1970s to allow for absolute and conditional discharge options in drug possession cases (Riley, 1998). While small changes were made to the existing legislation, Canadian drug policy was still very much centred around the idea that drugs should be prohibited, and those use who drugs should be criminalized.

The developments to Canadian drug policy in the 1960s and 1970s did not incorporate empirical evidence or scientific thought. Rather, these policies were largely influenced by the reactions of middle- and upper-class Euro-Canadian adults – as mirrored in the US. This population opposed the rampant use of illicit substances among younger generations and feared their subsequent involvement with the criminal justice system. As a result, the Le Dain Commission was formed, and amendments were made to the NCA. Despite these actions, Canadian drug policy remained soundly prohibitionist in nature, and the recommendations made by the Le Dain Commission were ignored. Essentially, the Federal Government disregarded the

research conducted by the commission to appeal to the masses of those who moralistically opposed drug use.

One Step Forward, Two Steps Back: Drug Policy in the 1980s and 1990s

By the mid 1980s, it was clear that there were serious limitations regarding the role of law enforcement and education. However, in 1986, PM Brian Mulroney announced that Canada was in the midst of a drug epidemic, despite reports indicating that drug use was declining (Erickson, 1992; Jensen & Gerber, 1993). This announcement came just two days after US President Ronald Reagan declared a national 'War on Drugs'. In response, the Canadian Government created a federal secretariat whose task was to consult with community groups and agencies to create a new national focus on a drug strategy (Erickson, 1992).

In May 1987, the Federal Government released the *Canada Drug Strategy*, which included a 'four-pillar' approach to combating illicit drug use. The four pillars included prevention, harm reduction, treatment, and enforcement, although the majority of federal funding was enforcement driven (TPH, 2018). Despite this shortcoming, the inclusion of the four-pillar approach marked a significant step towards a national strategy that incorporated treatment and harm reduction. This strategy was funded for an initial five-year term ending in April 1992 and was subsequently renewed for another five years (Riley, 1998). Following this term, heavy financial cuts were made to Canada's drug-related initiatives and the Policy and Research Unit of the Canadian Centre on Substance Abuse, which had been researching and documenting alternatives to drug prohibition, was closed (Riley, 1998).

Further, Canada introduced the *Controlled Drugs and Substances Act* in 1996, which replaced the NCA. This act did not consider the expert opinion from the Le Dain Commission (TPH, 2018). Rather, the new legislation remained soundly prohibitionist in nature, and further

powers were given to police and prosecutors to increase efficiency in processing those who use drugs and sellers (Riley, 1998; Hathaway & Tousaw, 2008). Despite the attempt to provide a balanced approach to combating illicit drug use during the implementation of the *Canada Drug Strategy*, the dominant policy regarding illicit drugs remained one of criminal prohibition.

The politics surrounding PM Mulroney's term in Federal Office were associated with the Canadian drug 'epidemic' in 1986. In previous decades, the factors that affected drug policy were largely based on societal attitudes and moral panics, yet the initiation of the *Canada Drug Strategy* and the renewed War on Drugs also appear to have been influenced by politics (Jensen & Gerber, 1993). Mulroney and the Progressive Conservative Party obtained a majority vote in 1984, however, within a year, his approval ratings dropped. By 1986, PM Mulroney's approval ratings stood at 37 percent (Jensen & Gerber, 1993). In order to bolster support for his Party, PM Mulroney announced the Canadian drug epidemic, which would ultimately create an opportunity for drug policy change; however, little change was made and progression under the *Canada Drug Strategy* was short lived.

Similar to previous decades, the Federal Government continued to respond slowly to the treatment of drug addiction. In 1987, amidst growing concerns over the spread of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), the Canadian government funded needle syringe programming (NSP). The Federal Health Minister allocated $100,000 to each province that agreed to match equal funding for the NSP. However, after only two years, Federal funding for the NSPs ceased, and provinces and municipalities were left to fund this harm reduction strategy on their own (Hayle, 2018). The Canadian Government's unwillingness to provide further funding was associated with the distribution of power over

healthcare (Hayle, 2018). While the Federal Government controlled drug policy, little support was given to treatment and harm reduction.

Moving into the Early 21st Century: Progressive Changes to Regressive Policy

The Canadian Federal Government was led by the Liberal Party at the turn of the 21st century. This Party emphasized the need for harm reduction initiatives and was actively seeking change to drug policy. In 2003, North America's first sanctioned SIF, Insite, opened in the Downtown Eastside (DTES) of Vancouver, BC (Dooling & Rachlis, 2010). This SIF allowed individuals who use drugs to safely inject in a clean environment, with nurses and other medical personnel available on site to provide sterile injection equipment, to aid in cases of overdose, and to provide educational material and treatment referrals (Dooling & Rachlis, 2010). The overall goals of SIFs were to increase access to health care and addiction services, reduce the spread of infectious diseases, reduce overdose related deaths, and reduce public injection use (Hathaway & Tousaw, 2008).

To operate legally, the Canadian Liberal Government exempted Insite from certain provisions of the *Controlled Drugs and Substances Act* relating to trafficking (Dooling & Rachlis, 2010). Insite was rigorously evaluated in the years following its implementation and multiple studies found positive results, which included the prevention of overdose deaths, a decrease in needle-sharing, a reduction in public injecting and injection-related litter, a reduction in vehicle break-ins and theft, and an increase in referrals to methadone treatment (Dooling & Rachlis, 2010, 1441). Despite these results, the future of Insite, and further harm reduction measures, became uncertain when the Conservative Party, led by Stephen Harper, was elected into office in 2006.

Despite the benefits of Insite, PM Harper did not support the harm reduction initiatives, and pulled the federal funding (Dooling & Rachlis, 2010). In 2007, the Federal Government released the *National Anti-Drug Strategy*, which removed harm reduction from Canada's four-pillar drug strategy while shifting the focus to the role of law enforcement (TPH, 2018). In 2008, the leadership for the new anti-drug mandate was removed from Health Canada and relocated within the Department of Justice, which demonstrated a clear shift in ideology within the government (van der Meulen, De Shalit, & Ka Hon Chu, 2018). This government also pushed to intensify the War on Drugs by proposing a 'tough-on-crime' approach (Hyshka, Butter-McPhee, Elliot, Wood, & Kerr, 2012; van der Meulen et al., 2018).

Canadian drug policy under PM Harper was not supported by evidence-based research or public demand (Hyshka et al., 2012). Further, the retraction of the harm reduction pillar in the *National Anti-Drug Strategy* and the tough-on-crime legislation contradicted the recommendations of the *Global Commission on Drug Policy*, the Supreme Court of Canada, and international trends (Hyshka et al., 2012). Thus, drug policy during this time was motivated by ideological principles of punishment and retribution, rather than by evidence-based research. It is not surprising that international observers viewed Canadian drug policies as anachronistic and ill-advised (Hyshka et al., 2012).

Finally Advancing: Drug Policy Changes in 2015

In 2015, the Liberal Party, with leader Justin Trudeau, won the election and initiated changes to Canadian drug policy. During its campaign, the Liberal Party was intentional in its agenda to legalize cannabis and increase harm reduction initiatives (Liberal Party of Canada, 2013). In 2016, Canada's current drug strategy, the *Canadian Drugs and Substances Strategy*, was released. This strategy is a comprehensive, collaborative, compassionate, and evidence-

based approach to drug policy that includes the four-pillar approach (Government of Canada, 2019a). Further, PM Trudeau outlined his intentions to legalize and regulate cannabis possession and use and to obtain bilateral agreements with each province and territory to improve access to mental health and addiction services (Trudeau, 2015 & 2017).

The Federal Government authorized legislative changes to fulfill their promises. On October 17th, 2018, the *Cannabis Act* was enacted in Canada, making cannabis possession and use legal for the first time since 1923. This act implemented a strict legal framework for controlling the production, distribution, sale, and possession of cannabis across Canada (Department of Justice, 2018). The goals of the act were designed to keep cannabis away from youth; to ensure that profits from cannabis sales would not support organized crime; and to protect public health and safety by making it legal for anyone over the age of 18 to access legal cannabis (Department of Justice, 2018).

In 2017, the *Good Samaritan Drug Overdose Act* was enacted (Government of Canada, 2018a). This act provides some legal protection for individuals who seek emergency help during an overdose, including protection from being charged with possession of a controlled substance or with a breach of conditions regarding drug possession (Government of Canada, 2018a). This act applies to anyone who seeks emergency support during an overdose, including the person experiencing the overdose and anyone else who may have been at the scene (Government of Canada, 2018a).

Trudeau's Government also supported the implementation of several harm reduction initiatives across the country. This government recognized that while treatment for addictions should be available, not everyone is an ideal candidate. In the meantime, the Trudeau

government supported several harm reduction initiatives, including: naloxone programs[10]; needle-exchange programs; and SIFs, SCFs[11], and OPSs[12] (Government of Canada, 2018b). Naloxone has been widely dispensed in many provinces and has been successful in reducing opioid-related deaths (Karamouzian, Kuo, Crabtree, & Buxton, in press). Moreover, a large body of evidence has demonstrated the effects of SIFs, SCFs, and OPSs on reducing various drug-related risks and harms, including fatal overdoses (Kennedy et al., 2019). Evidently, the current Federal Government has taken steps to support harm reduction measures and to reduce the effects of substance addiction on vulnerable populations.

To Dismantle a Century of Poor Decisions

Following the analysis of Canada's drug policy history, it is evident that this policy was largely based on social and political factors, rather than on scientific research and evidence-based practices. This led to prohibitionist policy that had an array of adverse outcomes, including high drug overdose rates, high rates of infectious diseases, high rates of incarceration for drug offences, high law enforcement costs, and no significant reductions in drug use (Hathaway & Tousaw, 2008). Evidently, prohibiting the use of certain drugs will not end drug use and addiction, nor decrease the associated harms.

It is encouraging that the recent changes to drug policy under the Liberal Government have focused on reducing the harms associated with illicit drug use, rather than strictly prohibiting substances and criminalizing those that use drugs. The current harm reduction-based drug strategies attempt to aid the most vulnerable and drug-entrenched populations in Canada,

[10] Naloxone reverses the effects of opioid-related overdoses.
[11] SCFs are similar in nature to SIFs, except the customer may only inject their drugs in SIFs, whereas SCFs allow all forms of consumption (Ponciano, 2018).
[12] OPSs are similar to SCFs, but are temporary facilities meant to address an immediate need in the community and can be in operation within weeks (Ponciano, 2018).

which is a historically overlooked population. Ultimately, these strategies are encouraging in that they are a significant step towards using empirical evidence and scientific thought in Canadian drug policy development.

Nonetheless, some still contend that the current harm reduction strategies are inadequate to address drug use and its associated harms. Van der Meulen et al. (2018) called for a rights-based, participant-driven, and gendered focus on drug policy development that recognizes substance use as a health issue, eliminates the use of incarceration and punishment for minor drug offences, and ensures that all drug treatment services are evidence-informed. Lavalley, Kastor, Valleriani, and McNeil (2018) argued that while drugs remain criminalized, advances toward addressing the overdose epidemic among vulnerable populations will remain futile. They also maintained that despite the recent increase in harm reduction practices, drug criminalization and policing practices limit the effectiveness of these measures (Lavalley et al., 2018).

Both van der Meulen et al. (2018) and Lavalley et al. (2018) contended that further improvements to Canadian drug policy should include drug decriminalization and evidence-informed services for addiction. Ultimately, these academics argued that while drugs remain illegal, those who use drugs will continue to be marginalized from society and further criminalized, decreasing the overall effectiveness of these specific strategies. Therefore, although the Federal Government has made progressive changes to Canadian drug policy, it is clear that further research on evidence-based policies and practices are warranted.

So What?

In reviewing the literature and considering the changes to Canadian drug policy in recent years, it is clear that a present-day study exploring the perceptions of those who have experienced substance addiction is needed. Accordingly, Canadian drug policy was reviewed

extensively for several reasons. First, to understand why the prohibition of drugs has been unsuccessful in addressing drug use and substance addiction, one needs to understand the establishment of this policy. As outlined, the foundation of Canadian drug policy is based on social and political factors, rather than on scientific research and evidence-based practices. This has resulted in prohibitionist policies that do not adequately address drug use and addiction. Moreover, while harm reduction strategies are a positive step towards using evidence-based practices and ensuring public safety, social and political factors remain an obstacle for serious drug law reform. Essentially, the social and political foundation of Canadian drug policy hinders major drug law reform, resulting in the continued implementation of ineffective policies.

Second, to recommend appropriate and effective action, one needs to understand the evolution of Canadian drug policy. Currently, Canada is in the midst of a drug-related overdose epidemic and has hastily pushed forward new drug policy, legislation, and strategies. While the harm reduction strategies have been successful in reducing the harms associated with substance use, there is clearly a need for changes to drug policy. As such, future recommendations must consider the history of Canadian drug policy, alongside the growing body of evidence-based literature. Acknowledging this history can prevent further repetitive action – such as the continued implementation of prohibitionist policies – that have been essentially ineffective in Canada.

Lastly, a thorough understanding of Canadian drug policy is needed to appreciate the findings of the current project. Due to the specific factors that have historically influenced Canadian drug policy, policy makers have ignored the opinions and experiences of people who use drugs. However, this population's perceptions are important in this policy discussion, as an understanding of their views on Canada's current and past drug policies will better inform the

decisions of policy makers. Nonetheless, the historical review highlighted the current shortcomings of Canadian drug policies and emphasized the need for consumer-informed research.

Chapter 4: Methodology

Research Question

There are few Canadian studies that examine how people who use drugs view drug policy. Given this finding, this research will explore how people who use drugs perceive Canadian drug policy. Specifically, this research will explore how this population feels about drug strategies and what they believe would be the best approach to prevent and treat substance addiction. The findings from this research will add to the growing body of research that considers the perspectives of those who are addicted to illicit substances – a population that is arguably the most affected by drug policy.

The Objectives

This research has several objectives. First, the study examines the perspectives of people with substance addiction and their views on drug policy. Second, this research reviews the history of Canadian drug policy in an effort to contextualize the current state of drug policy. Third, the study examines the consequences of government mandate changes on drug policy. Fourth, this project will analyze the perceived effects of punitive versus rehabilitative approaches to preventing and treating substance addictions. Lastly, the project investigates options for future drug policy changes that are supported by those who have experienced substance addictions.

Sample

The data for this research was obtained through qualitative interviews with 19 participants. To be eligible, participants must have experienced one or more substance addictions and must have been 19 years of age or older at the time of the interview. [13] For the purpose of

[13] Participants must have experienced a substance addiction, not including alcohol. While alcohol can be highly addictive and is viewed as a drug, it is not an illicit substance in Canada. Furthermore, while alcohol was made illegal for a brief period in the early 1900s, none of the participants interviewed would have experienced their addiction during the prohibition. Therefore, they would not have been affected by this drug policy. However,

recruitment, substance addiction was defined as the problematic, compulsive, and continuous use of a substance, such as opioids, stimulants, cannabinoids, hallucinogens, and sedatives, despite the negative consequences of its use.[14] Participants must have been addicted to any illicit substance for at least six months.

To recruit participants, a snowball sampling technique was used. Snowball sampling is a non-probability sampling technique where research participants recruit other participants for a study. Snowball sampling is used when participants are difficult to find. This particular method consists of two main steps: (1) identifying one or two potential participants in the population being studied; and, (2) asking those participants to encourage other individuals to participate in the study. In other words, a known potential participant was contacted by telephone and asked to participate in the study – this participant recruited other participants, which led to a sample size of 19 participants from the coastal, interior, and northern regions of BC. While the initial goal of the research was to interview 20 participants, saturation was reached after 19 interviews. Moreover, there was a natural conclusion after the 19th interview in that there were no new willing participants.

The age of participants ranged from 19 to 68 years. The mean age of the sample was 46 years, with a median age of 47 years. The sample consisted of 15 (79.0%) males and four (21.0%) females. Participants' level of education varied, as five (26.3%) reported not having a

alcohol is illegal to those who are under the age of 19. Hence, to avoid confusion and conflict of sampling, participants must have been 19 years or older to participate.

[14] An addiction to any illicit drug served as a qualifier to participate in this study. An addiction to cannabis, despite the drug being made legal in 2018, was also included as a qualifier for this study. This is due to the fact that cannabis was illegal for many decades before 2018; therefore, its previously illegal nature may have negatively affected the participants in the sample. Additionally, it is recognized that the addictive nature of both cannabis and hallucinogens have been widely contended. However, despite the lower probability of becoming addicted to these substances, these substances can be used problematically, and were therefore included in the sample. Regardless of these sampling conditions, none of the participants in the sample indicated they were only addicted to cannabis or hallucinogens. Rather, these substances were used alongside other drugs, such as opioids and stimulants.

high school diploma, eight (42.1%) reported completing high school, five (26.3%) reported having completed college level credentials, such as a diploma or post-secondary certificate, and one (5.3%) reported having a university degree. A majority (78.9%) of the participants were employed – two were retired, one was self-employed, and one was on work disability. The number of years of dependence on a particular substance varied, with a range of two to 33 years. The mean number of years of dependence was 17.6 years, with a median of 21 years dependent.

The first documented substance addiction was reported in 1971. At the time of the interviews, two participants disclosed that they were currently using illicit substances. Moreover, five (26.3%) reported that their addiction began before the age of 12, while nine (47.4%) reported that their addiction began during their teenage years (age 13 to 19), and five (26.3%) reported that their addiction started in adulthood.

Almost half (47.4%) of the participants reported using all types of illicit substances, two (10.5%) reported using all substances but heroin, and two (10.5%) reported using only heroin and methamphetamines. Six (31.6%) of the participants reported using different combinations of substances, which included combinations of cannabis, cocaine, crack-cocaine, lysergic acid diethylamide (LSD), gamma-hydroxybutyrate (GHB), MDMA, and methamphetamines. Ten of the participants (52.6%) experienced intravenous drug use.

All participants reported that, even after years of sobriety, they were still attending some type of treatment or counselling program. For example, 16 (84.2%) reported that they currently attend narcotics anonymous (NA) or alcoholics anonymous (AA) meetings, while three (15.8%) reported that they were currently attending counselling. Of these participants, two (10.5%) were currently on prescribed methadone and one (5.3%) accessed safe injection supplies through their city's harm reduction initiatives. A majority (57.9%) reported that they had attended a residential

treatment centre in an effort to overcome their addiction, while four (21.1%) relied on the 12-step program offered by NA and AA, and two (10.5%) attended counselling. Of these participants, four (21.1%) also used opioid agonist therapy, such as prescribed methadone or Suboxone.

Table 1. Sample Demographics and Substance Use Characteristics.

	N = 19
Gender	
Female	4
Male	15
Age	
19-29	4
30-39	1
40-49	6
50-59	3
60-68	5
Level of Education	
Less than High School	5
High School	8
College / Vocational	5
University	1
Employment	
Employed Full/Part Time	15
Self-Employed	1
Retired	2
Unable to Work due to Health	1
Years Dependent on a Substance	
2-9	5
10-19	4
20-29	9
30-33	1

(continued)

Table 1. (Continued)

	N = 19
Age Drug Use Began	
12 Years or Younger	5
Between 13 and 20 Years Old	11
Between 21 and 23 Years Old	3
Substances Used	
All	9
All Except Heroin	2
Heroin and Methamphetamines Only	2
Combinations (cannabis, cocaine, crack-cocaine, LSD, GHB, MDMA, and methamphetamines)	6
Intravenous Drug Use	
Yes	10
No	9
Current Drug Use	
Yes	2
No	17
Current Rehabilitation Effort	
12-Step Programs	16
One-on-One Counselling	3
Method Used to Overcome Addiction	
Residential Treatment	11
12-Step Programs	4
One-on-One Counselling	2

Research Design and Procedure

The research design was qualitative in nature and employed the use of semi-structured interviews with 19 participants. The interviews took place between 30 June 2019 and 1 October 2019. The interviews were semi-structured, meaning a formalized list of questions was not followed; rather, a series of open-ended questions were asked that allowed for a discussion with the interviewee. In particular, an interview guide was formalized that included: several

demographic questions; approximately eight general open-ended questions; and several word association prompts to organize and stimulate further discussion (see Appendix A: Interview Guide).

The interviews were conducted in English, as it is the only fluent language of the researcher. Additionally, all interviews were conducted one-on-one. All interviews were audio recorded and later transcribed verbatim for data analysis. Digital audio files were transcribed by listening to each recording and typing into a Microsoft Word document what had been said during the interview. This was completed after the interview.

Each participant was reimbursed with a $10 CAD Tim Hortons gift card for their time and possible travel expenses. On average, the interviews were a half hour in length, although they ranged from 15 minutes to one hour. Each participant was met in a location that was suitable and convenient for the participant, as well as safe and secure for the researcher. To complete the interviews, several trips were made from the coast to the interior of BC. Several interviews were conducted using a telephone, due to the remote location of the participant or by the choice of the participant (one participant felt more comfortable being interviewed by telephone). All participants signed and sent a copy of the consent form prior to the interview being conducted.

The data collected in the in-depth, semi-structured interviews was analyzed using an inductive approach. An inductive approach allows for research findings to emerge from the frequent, dominant, or significant themes within the data, without the restraints enforced by structured methodologies. This approach is different from deductive methods commonly used in experimental and hypothesis testing in which key themes are often obscured, reframed, or left invisible due to the preconceptions in data collection and analysis (Thomas, 2006).

Applying an inductive approach to evaluate the interviews was useful for several reasons. First, it condensed broad and varied text into a summary format. Second, it established clear links between the research objectives and the research findings. Third, it helped to understand the main themes that emerged from the data. The analysis of the findings was an iterative process that was completed by the researcher alone. Microsoft Word and Microsoft Excel were used to organize and draw themes from the data.

Ethical Considerations

Ethical approval for this study was obtained from the University of the Fraser Valley's (UFV) Human Ethics Research Board (see Appendix B: Certificate of Human Research Ethics Board Approval). The approval term was from 5 June 2019 to 4 June 2020. Participation in this study was completely voluntary, and participants were asked to provide informed consent prior to their participation (see Appendix C: Informed Consent and Consent of Participation Forms). If a participant withdrew from the study, they were aware that their data would not be used, and the interview recording would be destroyed immediately. Due to the nature of snowball sampling, complete anonymity was not possible; however, confidentiality was guaranteed. All possible measures were taken to ensure that written information could not be directly connected to any one participant, including the use of pseudonyms in the report.[15]

To ensure that the participants' information and identity were protected, the data was stored on a password-protected folder on a personal computer and only the researcher directly involved in this study had access to it. All identifying documents pertaining to the interviews were destroyed after the research was completed. Lastly, while the study did not use deceptive tactics, or intend to cause any physical harm to participants, some discussion topics had the

[15] The pseudonyms used within this report were chosen by the participants of the study.

potential to trigger difficult or sensitive memories, which could be mentally and emotionally strenuous. Therefore, participants were provided with information on how to access a counsellor should they require additional support or debriefing.

It should be noted that special considerations were taken for conducting research with individuals who have experienced substance addiction. First, steps were made to ensure the research relationships and interview environment were equitable as possible. Second, the right of the participants to make their own decisions about their lives and the degree of participation in the research process were respected and supported. In particular, the rights and well-being of the participants were privileged over the objectives of this project and the dignity of the participants was upheld during their portrayal.

Chapter 5: Findings

General Perspectives on Canadian Drug Policy: Advancing or Archaic?

To assess the research objectives, participants were asked about their perspectives on current Canadian drug laws and on current strategies being implemented in Canada. These strategies included harm reduction measures and abstinence-based treatment. When asked specifically for their perspective on Canadian drug policy in general, 13 participants shared their views without further prompting. Several similarities emerged from these answers, with only a few participant outliers.

Only one participant response supported the current Canadian drug policy. The participant stated:

> I think they're doing an ok job. I think there's going to be some things happening in the future, potentially legalizing certain drugs. I've heard they're trying to legalize pharmaceutical grade heroin for people who are addicted to that. I think they're heading in the right direction, I guess. (SMc)

While this viewpoint is optimistic, it reveals the support and desire for change in the Canadian context.

Some of the participants had mixed feelings on the current state of Canadian drug policy. One participant held the view that while Canadian drug policy has positively advanced in recent years, the legalization of cannabis was not a positive improvement. He stated:

> I think it's a lot better these days. My thoughts on the legalized marijuana, I have two thoughts. On one end it's kind of good, but on the other end, does it really change anything? It's almost giving people more opportunity to become addicts and they're just like any other person, they don't understand what they're consuming. They have a thought pattern on it, like it's not that bad, it's an herb, it's grown naturally, but it's like, sorry it is bad, and it will mess you up and it will just lead to other things… It comes down to education, you have to start when people are young, you have to change the culture, you have you change the idea that you're cool because you smoke marijuana. You're not cool because you smoke marijuana, you're stupid. You're robbing your brain, especially for young people. These young people that start when they're 12, I didn't start with weed until I was 19, I'm not saying I'm a superhero but it's better than when you're

> 12 and your brain is still forming. You're disrupting all those neuropaths and what chance have you got at becoming the best you can be. (Howler)

Evidently, there is fear of the long-term consequences of legalizing specific substances, such as cannabis, especially given the associated consequences for young people. Similarly, a second participant voiced his concern of the legalization of cannabis, by stating, "The legalization of pot to me was not a good thing, I don't like that" (Turtle). These respondents both felt that the legalization of cannabis in Canada in 2018 would be detrimental for those struggling with substance addiction.

Two of the participants voiced concern over the implementation of harm reduction strategies when speaking about Canadian drug policy. Referencing opioid agonist therapy, such as methadone and Suboxone maintenance programs, Joe Blow stated:

> My overall view on them [Canadian drug policies] is that they are not working, and I think they need to change them. So, I don't really know what their strategy is, but I know that their strategy isn't working, and I believe that a lot of their strategies are about harm reduction, and personally I believe that harm reduction does not work and is not working. And most of the addicts that I've tried to help and have worked with over the past 28 years, that have been on harm reduction [methadone and Suboxone] are using other drugs while they are on harm reduction, and harm reduction just enables them to use other drugs and to continue in their cycle of addiction.

The other participant, Princess, voiced concerns about the implementation of SIFs and OPSs in her hometown, reporting:

> What I get in my own hometown is that they have using stations and using places, which I get, people are going to use, and they might as well have a safe place. But honestly, I think when they're handing out free fucking needles, they're enabling it all. And making this whole problem. I'm not trying to sound like a bitch against addicts, but you're choosing to use. Those people that don't want to quit are just getting free needles. So honestly, I think the governments just enable it and keeping this vicious cycle going instead of deleting it. The only thing I do agree with around this city is we've built homeless shelters.

These concerns were shared by other participants when they were asked specifically about their views on harm reduction measures.

Seven of the participants in the sample reported similar views on Canadian drug policy – that Canadian drug policy is both outdated and overtly harsh on those struggling with substance addiction. One participant, Trojan Horse, stated that "They [Canadian drug policies] need change, a lot of its archaic." The theme of describing Canadian drug policy as archaic continued throughout multiple interviews. One participant described Canadian drug policy as "archaic" and then continued:

> We are trying to use jail and policing to deal with a mental, social, and economic problem more than anything else. It will never work. It hasn't worked. Prohibition of alcohol didn't work and our substance abuse problem in North America is getting worse and worse all the time. There are laws, where right now we are currently giving away needles for people to do illegal stuff. So, when a law says it's illegal, if we are given a clean injection site, we are actually as a society saying it is legal. And our laws need to catch up with that. That's what I fully believe. We will never beat this with laws. (Tank)

Similarly, while not specifically using the term archaic, another participant reported:

> They're not helpful, they're based on the Draconian US drug war. I think we've had it wrong for a long time and even though its proven wrong we just keep it and expect different results. And what we're seeing, all this rampant addiction, has been there for fifty years or more, there's deadlier substances now, there's generational addiction, and people think that this is the addict's fault, some people think this, and that influences government policy. But if the policy changed, you'd see such a benefit in health, not only to the individual people but society as a whole… It's going to take like 10 years like it did in Portugal of policy change and implementation of a totally different system of compassionate care that hasn't been here. So, you're not going to change 50 years of neglect with 1000 naloxone kits and getting everybody on methadone and then expecting it to be different but you're still coming at it from a punishment model and not a compassionate model. Until we as a whole get our heads wrapped around that and some politicians dying on the sword for that, if they have to, I don't see the policy changing. (Magtek158)

Essentially, these participants felt that Canadian drug policy is out-dated and has relied too heavily on past decisions relating to Canadian drug laws and drug policy in the US.

Several participants echoed these sentiments while also suggesting alternative solutions. One respondent stated:

> I think we're probably following the War on Drugs model too much, and in my opinion that's not very effective. Downward pressure from south of the border. So, a lot of time legislators' hands are tied. I think decriminalizing is a good start, so for me the cannabis legalization is a good start, at least to get the conversation going because I think filling our prison systems with addicts and people who need help, criminalizing them and giving them a record, I know too many people who did something as a young person and it follows them forever and have struggled. So, I think it needs to shift. (Ogre)

Similarly, Snowman noted:

> Honestly, I don't think when people are doing stuff to support their addiction they deserve to get the maximum sentences, like I don't think that they should get away with it, but it should be like, I was saying, I think it's Sweden but I could be wrong, where if you get arrested and you are an addict, they give you jail, treatment, school, job, and a place… I can't remember the exact numbers or anything. But going back to drugs and doing the same thing is lowered, because they give you the tools you need and here they don't.

Some participants also explored the link between punishment, crime, and shame, without prompting. One such participant reported:

> I think that it's a lot of punishment in it, and I don't think that is exactly like, I don't know, I don't think that it really fixes things, you know, and I really think that a lot of it is dehumanizing. Just the opinions on it and you know how it's all like, let's put them in jail, let's punish them like they are worthless. You know? So, I don't particularly like it. I'm not saying that I think it should be promoted but, it shouldn't be so like, no no no no, and shameful. You know? (Karma)

This participant brought the dangers of criminalizing and punishing individuals experiencing substance addiction to the forefront, by speaking of its dehumanizing process and the outcome of shame.

In general, and consistent with previous research in this area, these findings illustrate the differing views between the participants, despite their shared experiences (Darke & Torok, 2013; Lancaster et al., 2014; Lancaster et al., 2015). Notwithstanding the differences, it is clear that many respondents view current Canadian drug policy negatively and in need of change. Due to the generalized nature of the first question, participants were asked about their perspectives on Canadian drug laws, harm reduction strategies, and abstinence-based treatment programs.

To Legalize, Decriminalize, or Penalize

Participants were asked about their views on the recent legalization of cannabis in Canada and whether they believed other illicit substances should be legalized or decriminalized. Five of the participants objected to the legalization of cannabis in Canada. Some of these participants noted concerns about the difficulties of enforcing laws, such as preventing intoxicated driving. Another participant, Con, opposed the legalization of cannabis based on his own experiences with the substance, stating:

> I used to smoke a lot of weed, so, I feel that I can say that when I did smoke weed, I wanted it to be legal, and I was like, oh it's not that bad, but when I quit, I realized how much it was affecting me. So, I just think that those people are caught up in their own shit and they don't really realize how much it's actually affecting them.

Comparatively, 11 of the participants supported the legalization of cannabis in Canada. These participants noted the benefits of using the drug. Some participants noted that cannabis use was less harmful than drinking alcohol. Other participants supported the legalization because of its health benefits to those struggling with chronic pain or certain diseases and disorders. A participant, who had admitted to using cannabis for health reasons, stated:

> My methadone has come down, I am off my anti-depressants, I am off my anti-psychotics, like it [cannabis] has replaced a lot of stuff in a good way. And I don't smoke all day every day. It's not like I wake up and I'm like fuck I need one now, usually I get what I have to get done in the day, and then at night, I have a puff. (Snowman)

This participant noted that like anything, cannabis, if used, should be used in moderation.

Moreover, one participant reported little change since the legalization of cannabis, either than seeing the drug around more than before. Rusty stated: "With it being legal, I'm not sure if it has changed much. I haven't noticed anything else other than you see it a lot more than you normally would. Other than that, I don't think it's hurting anything." This supports the perspective that the legalization of cannabis has not resulted in increased harm to members of

Canadian society. These perspectives were consistent with the findings of Osborne and Fogel (2017), who also found that a majority of Canadian participants favoured the legalization of cannabis. Lastly, several others noted that the legalization of cannabis was "… a big first step" for Canadian drug policy. These participants reported being hopeful that the legalization of cannabis will lead to the legalization or decriminalization of other illicit substances in Canada.

Five participants opposed the legalization of cannabis, which is the same number as those who opposed the legalization or decriminalization of other illicit substances; however, the five participants in each group were different. This is because two of the participants opposed the legalization of cannabis yet supported the decriminalization of other illicit substances. Comparatively, two were against the legalization or decriminalization of other substances yet supported the legalization of cannabis in Canada. Only three opposed all forms of legalization and decriminalization for all substances, including illicit substances and cannabis. Hence, five of the participants reported being opposed to the legalization or decriminalization of illicit substances. Howler voiced concern about the effects of legalizing certain drugs, by stating:

> Just think of the mayhem that would start if you decriminalized heroin. You'd have people lining up for miles at wherever they dispense it. It's bad enough the way it is now, they make it too easy for people now.

Comparatively, many voiced their support for the government to legalize or decriminalize other illicit substances.

Those who spoke of legalizing other illicit substances indicated the need for a legal and safe supply of heroin offered in Canada. One participant reported:

> When I went to university I looked into studies and some of the things they did, pilot project in England, and you know, I mean they ended up having people who are heroin addicts pick up their heroin every day, and go to work, and they were committed people of society again and contributing. And they are not kicking in your back door, or businesses back door to steal money, because they are getting their heroin every day and they just go to work like everybody else. And so, what I would like to see is the

> government really do an in-depth study or study it more, to come up with what that is going to look like. You know it's fine for the question of thinking legalization is a good thing, but I think we need to have more information to really go, yea that's a good idea! Or I am not so sure. So, yea, a lot more information would really be needed, I mean there are studies, like look at Portugal, and what they've done. There are a lot of countries, Switzerland, there are a lot of countries that have done this. Will it work in Canada? I don't know. Being next to a country that has Neanderthal ideas about drug addiction, amongst other things? But so yea, will it work in Canada? I don't know… I think we need to look at it more, we need to put more money towards it and move in that direction of change. I just don't know what that looks like to have it. It's going to be regulated, but how is the question. So, I am for it. I mean, people are dying. (Lovern)

Another participant, Centaur, added:

> If you are going to legalize one, you may as well do them all. Do the ones that are causing all the damage, major damage, and that's the heroin and the crack that is being made and the people that are having. How stupid are they? I mean, get the drugs legalized and under control so that our friends, and our families, and our loved ones who are smoking that shit aren't going to die from it, because it's actually got some substantial drugs involved in it.

The need for more research on the effects of legalizing certain illicit substances resonated with many of the participants.

Another participant, Tank, anticipated how others might react to the idea of legalizing heroin and other illicit substances and countered it by asserting:

> I know there is a lot of worry and I hear a lot of people talk, well if we legalize, we can't legalize heroin, and I'm like "why? Would you suddenly do heroin tomorrow if it was legal?" and besides, if we licensed it and monitored it and somebody is overdoing it, we could then intercede on their behalf. Right?

This participant argued that legalizing heroin and other 'hard' drugs would not necessarily increase their use among the general Canadian population; instead, the legalization of these substances would increase the ability to monitor and help those who are using.

Legalizing or decriminalizing illicit substances has been an increasingly common approach in many countries to help reduce the harms associated with substance use. For example, Switzerland, the United Kingdom (UK), Germany, and the Netherlands have offered

prescribed heroin under medical supervision (Transform Drug Policy Foundation, 2020). Heroin-assisted treatment (HAT) is used to treat long-term addiction to illicit opioids, with the addiction being unresponsive to other forms of treatment. The use of HAT has supported arguments for the legalization of a safe drug supply in these countries (Transform Drug Policy Foundation, 2020).

In countries, such as Portugal, Costa Rica, the Czech Republic, the use of illicit substances is not punished criminally, and the possession of small amounts of the substances are allowed (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2017; EMCDDA, 2019). These countries have formed their own drug policies, in which illicit substances are decriminalized. These countries have succeeded in decreasing the spread of HIV and AIDS, and decreasing drug-related overdose deaths (EMCDDA, 2017; EMCDDA, 2019).

Many of the participants agreed with decriminalizing all illicit substances in Canada and implementing a medical model approach, as seen in countries such as Portugal. Although these arguments varied, several participants noted how decriminalizing drug use and possession would reduce the criminalization and the subsequent stigmatization of people who use drugs. Jesus argued to "… decriminalize the petty addict, the 16-year-old kid homeless on the street corner peddling a dime bag of blow because somebody gave it to him but penalize the guy that brought in the kilo." Echoing these sentiments, another participant, Joe Blow, maintained: "I think they [illicit substances] should all be decriminalized. And then we should go towards a treatment model in society, where we are encouraging people to seek help for their problem." While the participants did not necessarily support illicit drug use, they supported the idea that decriminalization of illicit substances could help people recover from addiction.

A participant who eloquently explained this idea stated:

> I don't think all drugs should be legalized, they should be decriminalized. They do a really go job in other parts of the world, Portugal is one example, in New York they have

> drug courts that have taken a lot of the pressure off the courts. The majority of people doing drugs are not doing criminal behaviour, there's a faction that are, and I think some of that driven by the policies because they're demonized and criminalized and not engaged in society. That's not going to totally go away because you decriminalize drugs but a large majority of it would and for the stuff that's not, there should be consequences for criminal actions but separating those two things in people's minds, criminal action from people who use drugs, because the use of drugs has been criminalized for so long in North America that people associate the two as one thing. A lot of people on the whole assume every homeless person must be an addict and using, or every person with mental health challenges must be an addict. These are some of the attitudes that have prevailed and helped policy lagged behind, and it doesn't really matter which came first, the chicken or the egg, the criminalization and demonization of drug addicts has helped sustain those attitudes in society, or those attitudes have help sustain the policy, but they feed each other. (Magtek158)

Given the negative implications and stigmatization that result from the implementation of these laws, the continued criminalization of drug use is viewed as harmful.

Another participant agreed that illicit substances in Canada should be decriminalized but was sceptical of this becoming a reality. In summary, the participant maintained that models of decriminalization have been successful in other jurisdictions, such as Portugal; however, due to the prohibitionist nature of Canadian drug policy, he was uncertain of this model being successfully implemented in Canada. Despite this uncertainty, the participant was in support of researching and testing the idea.

A majority (57.9%) of the participants supported the legalization of cannabis in Canada. Moreover, a majority (63.3%) also supported either legalizing or decriminalizing other illicit substances in Canada. These findings are important to note, since decriminalizing illicit substances and legalizing a safe supply of heroin are both policy options being discussed in Canada (Angus Reid Institute, 2019; Corace et al., 2019). Moreover, due to the overall support for these law reform strategies, these options will be further considered and analyzed in the next chapter.

Reducing Harm: It Should be a Simple Answer, Right?

Participants were asked to describe their views on harm reduction measures. These included SIFs, SCFs, OPSs, opioid agonist therapy, and naloxone kits. Perspectives among the participants varied, with some supporting all harm reduction measures, some supporting certain methods, and others not supporting harm reduction measures at all. The opposition or support for these strategies seemed to be largely based on the strategy's perceived effectiveness. Moreover, many participants voiced uncertainty on this topic.

Those who opposed the use of harm reduction measures in Canada referenced their own experiences with substance use. Sassy stated, "From my personal experience, the injection sites, if there were those sites I probably would've used more because it was hard for me to get paraphernalia." Another participant, Joe Blow, who used the term harm reduction to mean opioid agonist therapy, reported:

> Harm reduction measures aren't working… most addicts that go on harm reduction are only using it to enable them to use other drugs, and not be dope sick, and they are using. If harm reduction was monitored way more closely, and if you had people who tested positive for any other drug while they are on harm reduction, and they were removed from harm reduction immediately, the abuse of that system would go away, but there's a lot of financial gain and kickbacks to doctors and methadone recovery houses, and it's all about money, right? Those people need to be in it more for the actual help and helping the addicts than the money that is involved.

In this instance, the participant did not agree with the implementation of methadone and Suboxone maintenance programs, due to availability of other substances. Comparatively, Rusty commented positively on the methadone maintenance program, maintaining, "I think the harm reduction can be trouble at times, but I've also seen guys I work with come in on methadone and within six months can slowly ween off that and actually have long term recovery." Evidently, participants have divided views on the benefits of this harm reduction measure.

There was also concern about the distribution of drug paraphernalia to people who use drugs. These participants argued that while this practice was a positive advancement in drug policy, there needs to be more addictions resources offered. One participant expressed:

> Just getting them off the streets so we can't see them doesn't solve the problem, not even slightly. So, I am glad we are moving towards that, but we need to move farther so that we invest more in actual treatment so that when somebody says that they need help, our response as a society should be, "Where are you? Somebody's coming." Not, "We are putting you on a waiting list and in a month or two you'll make it in". That's my belief to really start solving the problem, in the meantime I think that it's good the we're giving some clean needles, I just wish they had a plan to pick them up. And just handing them out, us junkies aren't really known for our cleanliness. It's not on the top of the list, right after you bank back a few points of heroin. (Tank)

These comments reflect how the perspectives among the participants vary. Many of the participants formed opinions on harm reduction strategies based on their own lived experiences with substance addiction. Some had negative experiences with certain harm reduction strategies, which resulted in negative perspectives. Others understood the benefits of the strategy yet highlighted the strategy's weaknesses. Regardless of these variations, the benefits of harm reduction strategies were contended.

Despite these concerns, there were several participants who indicated their support for harm reduction measures. Many noted the benefits of harm reduction measures, maintaining that they work to keep people who use drugs alive and well during a time that they may not necessarily be capable of quitting. AJ explained:

> I believe in every strategy to help and to minimize the effects of drugs is a good strategy. Harm reduction helps people sometimes to be less scared of and less imprisoned, you know what I mean, so in the long run it works both ways, to the government too, like less spending money on drugs, that they want or not, they criminalize, you know, people for the drugs, they spend more money on keeping them in prison, which is useless, right? And then when they do this harm reduction, they can have more chance to educate people about drugs and the rehabilitation, so it's kind of like, in the long run, I think they can save more people or change a lot of lives that way, than imprisonment.

Another maintained that harm reduction measures are "… a step in the right direction…" and "… anything, be it safe injection sites and mobile clinics passing out needles, stuff like that is positive" (Ogre). These participants recognized the need for increased safety measures for people who use drugs, to avoid the spread of diseases, and to prevent overdoses and drug-related deaths. One participant, Karma, who has utilized harm reduction strategies in her community, stated:

> I think that it is really good that they have harm reduction, because I know that there would be a lot of people with HIV and stuff like that if there wasn't harm reduction. And I might even have HIV if there was not harm reduction. You know? And I think that even the people that you know, even if there was no harm reduction, there would be people that get diseases, and if they become clean, they still have a disease for life. So that is bad, and that could spread to more people that even never were drug users. So, I think it helps the population, our community.

This participant argued that harm reduction measures help to decrease the health risks associated with drug use.

Lastly, several participants indicated their support of the take-home naloxone kit program in Canada. They explained that, due to the increase in opioid-related overdoses, the need for naloxone has increased in recent years. Centaur explained: "The last three years I have attended a total of 14 different people who have overdosed, to which I have had to either pump their chest, or I had to inject them with Narcan." Another participant, Rusty, similarly spoke about using a naloxone kit on an overdosing stranger, stating:

> Last week I actually had to bring somebody back in a Subway and it just happens that they had a naloxone kit on them. It's great, there's just not enough people that are educated on it, for example the workers at Subway had no idea what to do if someone overdosed in their store and luckily, I just happen to walk in and hit them with the naloxone. So, a little more education for the community would be great but I think that's starting to come together too because they are doing a lot more awareness with the fentanyl crisis and the overdose crisis.

These examples illustrate how important the distribution of naloxone kits is, as they are routinely used to save lives. In general, the participants of this sample were conflicted in their views on harm reduction measures.

All or Nothing, the Machine called Abstinence-based Treatment

A majority of the participants viewed abstinence-based treatment positively. This is not surprising, given that a majority (57.9%) had attended a residential treatment centre to overcome their addiction, while four (21.1%) relied on the 12-step abstinence-based program offered by NA and AA. Additionally, 16 (84.2%) reported that they currently attend NA or AA meetings regularly. Consequently, 14 (73.7%) of the participants perceived a combination of a treatment program, counselling, and partaking in NA and AA meetings as the most effective approach. One participant reported:

> I think it works. I'm in an abstinence-based program and I think that works really good. I don't like the other wet facility very much because they're not helping the problem in any way. I think there are more recovery houses where people having a better shot at getting the problem fixed. The recovery house where I'm at does a great job. (SMc)

The successful completion of an abstinence-based treatment program may have affected the policy views of the participants in this sample. Critics may argue that this diminishes the value of these findings; however, the study aimed to gain the insights of the participants – these insights being made based on the learned knowledge and lived experiences of the participants. While it is recognized that there may be a higher rate of support for abstinence-based treatment in this sample, the responses are inherently valuable. Moreover, there were several themes drawn from the participants' responses.

Though a majority of the participants supported abstinence-based treatment avenues, many reported the need for more available and affordable treatment options. One participant, Karma, who supported abstinence-based treatment, stated:

> I think it's unfair that they have treatment centers that you have to pay a lot of money for though, because, you know, not everyone can do that. Like, why do they even have those? But there's a lack of treatment too. Like I know there's not enough for everyone. So, you have to get on a long waitlist and that's not always good because you might be in a different place in a year.

Similarly, Sassy recognized the difficulties of getting admitted into affordable treatment, explaining, "… if you don't have money, I don't know how you'd get treatment, like I wouldn't have ever. And there are ones where you don't pay but there's such waiting lists." Moreover, Princess maintained that "We need cheaper rehab facilities, so people can afford to get that kind of help."

Participants also expressed the need for more treatment beds. One participant stated:

> Abstinence based treatment programs? They're wonderful, we need more. And we need more free ones, not everyone can afford $13,000 a month for treatment programs. The government needs to look at getting people to abstain somehow to get them back integrated into society and feeling good about themselves. When you've got homeless people that hate life and aren't happy it's just a downward spiral. And then the crime that spews out of the addiction like the B&E's, drug dealing, prostitution and on and on, it's a plague. We need more treatment centres. (Turtle)

These findings are important, as many of the participants indicated that those who are deeply entrenched in drug use often lack family and positive peer support or the money to afford immediate treatment. Subsequently, this deters those in active addiction from seeking and successfully completing abstinence-based treatment programs.

Some of the participants also indicated that while treatment programs are beneficial, they need to incorporate holistic healing methods. AJ explained:

> The treatment programs, in my view and in my studies, I feel like you can't treat one thing without the other. Like it's going to have to be dual treatment, like you can't treat addiction without treating other parts of like, the environment, you know what I mean, the background, the disorders, along with the addiction. So, I think you have to be treated all at once in order to really beat addiction. Cause if someone, they do drugs because of depression, then if you don't treat the cause of the depression, why they are depressed, then they will keep doing it. Like kids that grow up that are homeless, and they are dysfunctional, they have to steal and when they do all those things, they become

> depressed and anxious, and live in fear, and drugs become almost like a medicine to function or feel comfortable, like less care. So, if you want to treat that addiction, you got to make sure that these people have a life worth living. Like, you know, they have access to education, access to a home, stuff like that, so I mean, the whole community and the government have to be a part of treatment, in a sense.

This participant emphasized the need for treatment programs to consider and respond to the unique needs of every individual. This includes considering the lived experiences and past traumas of each patient, before creating a treatment plan for that individual.

Several participants noted that abstinence-based treatment programs are largely unsuccessful when the individual is forced to participate. Joe Blow explained, "Well treatment programs are wonderful, if you get the addict when they are willing to get clean…", while Princess added, "Unfortunately, I think many people go to treatment that are forced to and they don't really want to get treatment and they relapse right away." Another participant, Con, who was not entirely in support of abstinence-based treatment programs, stated:

> I guess they kind of work, they work for people who want to do them. If you want to quit, then you'll quit, but if you don't then no one can force you to. So, they are effective for people who want to, or maybe if they've gone rock bottom or something like that, but otherwise, I don't really know. They don't seem that effective. And people don't seem to really like it, the whole stigma around it where people don't really like that sort of thing.

Participants agreed that abstinence-based treatment programs are beneficial for those interested in overcoming their addiction; however, these programs are usually not beneficial to those mandated to participate.

Only two of the participants opposed against abstinence-based treatment programs. Both had experienced abstinence-based treatment in some capacity yet were sceptical of their benefits. Moreover, one participant, Lovern, explained the danger of a uniform approach to substance addiction, stating:

> I think there was this philosophy of one size fits all and there is still that mentality among many of the old timers in alcoholics anonymous and narcotics anonymous, that one size

> fits all, that we are the answer. The book that I read in alcoholics anonymous says that on the very last page, says that we know only a little, you know? We know only a little. And so, I think that abstinence-based programs had their day, and it will be a good day when they are gone for good in that regard where we forced people to do this, abstinence-based, no. People need choice. People need freedom to be able to decide what's best for themselves. You know, there's this idea that on one hand, that addicts can't decide for themselves, and don't, you know, all people, you, me, we know the sum total of all our days and I do, and you do, and we know what has worked for us in our lives and what hasn't. No one else knows, but we do. And with that information we really need to choose, well I tried that, and it really didn't work for me and I didn't feel comfortable, well then, it's time to look at something else. So, yea, I think these other options need to be even more available to people and yea, abstinence-based, I don't know.

While many of the participants had experienced abstinence-based treatment programs during their recovery, there were two suggestions made to improve these programs. The first suggestion was to increase treatment availability and affordability. The second recommendation was to increase treatment options that focus on each individual's specific needs. Apart from these suggestions, it is evident that abstinence-based treatment programs should be entered willingly, as the effectiveness of the programs can be hindered by an individual's reluctance to become and remain sober.

Canadian Drug Policy: Have You Felt the Changes?

All of the participants indicated that they felt the approaches taken by the government towards substance addiction have changed in Canada. Moreover, a majority (63.2%) agreed with the perceived changes. Many indicated that they agreed with the increase in harm reduction measures and low-income housing developments that have been implemented by the government in recent years. One participant explained:

> I haven't been around that long, so I don't know, but it seems like they are more like, I can go to interior health and get supplies, I can go to a pathways and get counselling or drugs that help, and there are some places that are accepting about it, whereas back in the day, I think it wasn't allowed at all. I think it was so shameful and a secret. You know? So, I think we are coming around to accepting, not accepting it, but it being like, okay let's help you not just like, you're bad. Yea, I am glad. It's better. (Karma)

While many identified and supported the changes to Canadian drug policy, many argued that more change was needed to address the current epidemic. Becky maintained "I think that they should be doing more, like, I do agree [with the changes], I just think they could be doing more." Mirroring these sentiments, another participant stated:

> It's progressed, has it progressed fast enough? You know, I guess if you talk to a mother or father who has just lost their son or their daughter, not quick enough. So, do I think that it's a good idea? The faster that we can progress with studies and ideas and move in a direction towards more harm reduction and legalization, and the regulation of that, the better off moms and dads and their children, whoever else's families are going to be. (Lovern)

Additionally, a third explained:

> Yeah, it's changing, I agree with them, there's more talk than there is change, like there's a lot of discussion. I do feel the swing starting, I think it started about 5 years ago and we're about a quarter of the way into the pendulum where it needs to swing to where we're really doing well, having all these resources available and treating people. (Magtek158)

It is clear from these statements that while the recent changes in legislation and strategies are generally supported, there is still a need for further innovation.

A minority (31.6%) indicated that they did not support the changes the government has made in recent years. This is due to the perception that these changes had not fixed or improved the underlying causes of the overdose epidemic, rather these changes were viewed as addressing merely the symptoms of a greater problem. Moreover, those who opposed the implementation of harm reduction measures were also opposed to the government's mandate in recent years. One such participant, Tank, asserted:

> I am seeing quite a change, I am seeing a lot more investment and a lot more political will to help, but I am afraid that I am seeing the approach stay much the same that is has been for a long time. As I say, just giving somebody a place to live so we can't see them in the park and then clean needles has not worked, they are still out doing the same crime that they were… Drugs are not the problem, they are a symptom of an underlying problem and if we never deal with the actual problem, we will never get rid of the symptom.

In a sense, the participant is speaking to the inability of harm reduction strategies to address the root causes of substance addiction.

Beneficial or Harmful? Punitive vs. Rehabilitative Approaches

One objective of this study was to analyze the perceived effects of punitive versus rehabilitative approaches to preventing or treating substance addiction. To do this, participants were asked about their views on tough-on-crime and harm reduction approaches – specifically whether these strategies were beneficial or harmful to someone experiencing a substance addiction.[16]

Is there Love for Tough Love?

The participants were asked if, in their own experience, they felt tough-on-crime approaches were beneficial or harmful to someone experiencing a substance addiction. A majority (78.9%) of the participants stated that tough-on-crime approaches were harmful. Notably, only one supported this approach, stating "Who cares? If they are breaking the law, let the time suit the crime" (Centaur). Those who opposed the use of tough-on-crime approaches explained that punitive measures, such as harsh penalties for drug possession and use, were harmful to those in active addiction. These participants agreed that the criminalization of people who use drugs contributes to an increase in shame and stigmatization. Moreover, the participants seemed to agree that punitive approaches do not address the root causes of addiction and

[16] The participants were asked their views on harm reduction approaches, since rehabilitative-based drug policy generally involves an emphasis on strategies aimed at reducing drug use and its harms. Treatment, programming, and counselling are all associated with a rehabilitative approach. Nonetheless, harm reduction strategies, such as SIFs, SCFs, OPSs, opioid agonist therapy, and naloxone kit programs are arguably rehabilitative in nature, as they serve as a stepping stone before an individual is accepting of treatment, programming, and counselling. Moreover, harm reduction strategies are also often used alongside treatment, programming, and counselling, as a means to reduce harms before an individual has fully recovered from their addiction. Essentially, harm reduction approaches were used to guide this interview question, since these approaches are currently being emphasized by the Canadian Government's drug policy mandate, which is a mandate focused on the rehabilitation of those with substance addiction.

subsequently lead to institutionalization and further criminal behaviour. Lastly, many explained that while people who use drugs should not be penalized for drug possession or use, there should be harsh penalties for the non-addicted drug supplier.

When describing the negative effects of punitive measures, the participants spoke of their own increased shame as they became criminally entrenched. Jesus explained:

> Well when I first started using, well I started using for all sorts of stupid reasons, but what I found was that I was ashamed that I used, so I used to feel not ashamed, and the more I kept using, the more ashamed I got which meant the more I had to use. And it led to petty crime and theft and then the more I got punished for it, the more ashamed I became, so the more I kept using because I felt ashamed. So, it just compounds it, I mean, it makes it worse, it's stupid. Like what, you did a bad thing, we are going to make you feel like shit and we're going to alienate you from friends, family, and loved ones, we're going to exile you in a corner somewhere, because the rest of the world hates you. But go fix yourself. So, no, it's the worst thing you can do.

This sentiment was shared with other participants in the study. For example, Becky maintained:

> At the end of the day, they are just people, they are just people like you and I, and I don't think that ostracizing them because they have an addiction makes them different in any way, and I think that there could be different measures, so instead of criminalizing them and putting them in prison, they should be provided with treatment, or a recovery program, or something like that. As opposed to like, "You are going to jail, because you are addicted to heroin!"

These examples indicated a negative effect associated with the criminalization of people who use drugs. Unfortunately, this is not the only negative outcome of utilizing punitive measures against this population.

A second theme that emerged was the fact that these measures simply do not address the root causes of substance addiction. One participant explained:

> I don't think sending someone to jail because they're a heroin addict helps the situation. They need treatment, they need to get to the source of their addiction. All that incarceration does, in my opinion, and I've been there, it gets you institutionalized in these places, you get hardened in these places. (Turtle)

Another participant, Magtek158, echoed these sentiments by stating that tough-on-crime approaches are "…harmful, completely… Obviously that hasn't been working but people are wanting to punish them harder. But we should be dealing with their substance abuse, and then dealing with that emotional, childhood trauma, whatever is causing this and see what happens." Ultimately many of the participants shared the opinion that tough-on-crime approaches neglect the causes of substance addiction and only address the symptoms. This results in criminalization and institutionalization – an outcome that is not necessarily conducive to rehabilitation.

A third theme that emerged was the view that tough-on-crime approaches increase criminal entrenchment. When responding to the benefits or harms of tough-on-crime approaches, Snowman asserted:

> Oh, it is definitely harmful. Like I know for sure that if I didn't end up spending so much time in jail over fucking drugs, not drug charges, but stuff to do with drug related charges, I wouldn't have gotten into everything else that I did, because, like, you learn so much. It's pretty much university for criminals. Right? And somebody, like I agree that drug addiction is an illness, right? Like it's not a choice, it's an illness, so like, would you lock somebody up because they are diabetic? Or they are down-syndrome? Or like, you know. You don't put them in jail. It's not the way to deal with it.

This participant was not alone in suggesting that incarceration increased their propensity to commit more crimes and to continue using drugs. Another participant, AJ, explained:

> I've been arrested for possession and for something like a very small amount, and I was just imprisoned for like a possession, and like, when I go to jail, like, I remember I did, in jail I met more criminal people and so I had more connections of criminal mentality, and I would sell drugs too and so I would get hooked up in that business and that lifestyle, and I know more connections with criminals, so it didn't help me and I don't think it helped the government either because when I go it costs a lot of money for the government to keep me in prison, and at the same time, it doesn't benefit me or the government.

These examples illustrated how incarceration can lead to increased negative peer connections and solidified criminal lifestyles. Ultimately, tough-on-crime approaches were not perceived as

beneficial to those struggling with addiction, as they were perceived to increase shame and stigmatization, decrease the chances of rehabilitation, and increase criminal learning.

The last theme to emerge from this question was the agreement among participants that tough-on-crime approaches should be used against those who are supplying the drugs. Princess mentioned, "If you're a drug dealer, you need to fucking go away and stay away. You're choosing to sell hard drugs to addicts and you're destroying lives. Those people need to be put away and stopped." Another participant, Joe Blow, who agreed with this idea, stated:

> I think they [tough-on-crime approaches] are actually harmful, now, harsher penalties on trafficking, especially on traffickers that aren't actually addicted to drugs, right? The people that are actually making money off of the misery that's going on. See, there are two types of traffickers, there's the traffickers that are making profit off of it, that don't use drugs, and then there are the ones that are trafficking merely to support their addiction. The ones that are trafficking merely to support their addiction, giving them harsher penalties really isn't helping them, it's just allowing them to be in a different environment and building a network of people that are involved in the same stuff, so it doesn't help the solution at all. Harsher penalties for people who are trafficking narcotics who are not addicted, I'd be all for that. Because in my opinion, those people are really scummy. Now, when you are addicted to drugs and you are selling drugs because you are addicted, well sometimes you are doing it because that's what you go to do, you know?

These sentiments support the view that the personal possession and use of illicit drugs should be decriminalized in Canada. The participants argued that if a medical model approach was imposed, more individuals could seek help for their substance addiction. Furthermore, they maintained that this option would still allow for drug traffickers to be charged and convicted of crimes, which they strongly supported. In general, the negative views on tough-on-crime approaches among the participants supported arguments for decriminalization.

The Winner of the Least Effective Strategy Vote Goes to…

When participants were asked about the least effective approach in Canada, 52.6% (10) indicated criminalization and incarceration. Many explained that treating those with substance addiction would be more effective than charging, convicting, and imprisoning them. Joe Blow

asserted that the least effective method for handling people with substance addiction was "… treating them like criminals instead of treating them like people, right? Addicts are somebody's son, daughter, mother, father, somebody's child, right? We need to start treating them more like people." These participants recognized that there were harms associated with the incarceration and criminalization of people who use drugs, which led to the belief that this option was the least effective for those struggling with substance addiction.[17]

Strategies to Save Lives: Is it Enough?

A majority of the participants reported that harm reduction approaches were beneficial for reducing drug associated harms and drug-related deaths. However, many voiced concerns that these strategies were merely short-term bandage solutions, failing to address the more important issues in Canada. Moreover, many reported that improvements are needed to the implementation of harm reduction strategies to ensure that a connection between harm reduction and treatment is made.

There were two participants who believed the use of harm reduction strategies were harmful. They both maintained that harm reduction strategies enable those who use drugs to continue using. One explained that harm reduction measures are "definitely harmful. I think it helps them out, it keeps them going like, 'It's not a big deal if I overdose now'" (SMc). Comparatively, another participant, Magtek158, stated:

> They're obviously beneficial. We've seen huge cuts in overdose deaths, the last I heard there hasn't been an overdose death in the Vancouver safe injection site. Even the handing out of clean paraphernalia, you even have some questions, like my sponsor, if

[17] These perceptions are consistent with previous research that has illustrated the serious health and social harms of criminalizing individuals for using and possessing illicit substances (de Villa, 2018). Some of these recognized harms included: increasing negative stereotypes and stigma of those who use drugs from service providers, family members, and the general public; creating criminal records that hinder employment and ability to find housing; enhancing difficulties accessing harm reduction services; forcing individuals into unsafe spaces and high-risk behaviours; increasing overdose and blood-borne infections, such as HIV, hepatitis, and tuberculosis; creating an illegal drug market; and costing Canadian police, courts, and prisons an extra two billion dollars a year to enforce drug laws (de Villa, 2018).

> you're enabling. But when we were using people just overdosed and died because they didn't get help and then you just went through their pockets for what they didn't need anymore. And I asked him if he ever smoked out of a light bulb or out a tin can, did you ever shoot up with puddle water? Of course, he did. It didn't change the fact if you had a good needle to use, nobody enabled him, and he used for 30 years. And he said, "Oh yeah that's a good point". It's very beneficial, they're great engagement tools, especially the safe use sites. Another mistake that people make is thinking people want to be using, I would be very shocked if 10% of the people we housed said this is the life they wanted, and they wanted to keep using.

Those who supported harm reduction approaches argued that harm reduction saves lives. Karma explained:

> I think it's good, because some of those people, like it could be your daughter, and you know, if there wasn't Narcan then your daughter could be dead. And since there is Narcan and she can get saved, maybe in a couple years from now, she might recover and become really successful and have a good life. But if there was not Narcan, she would be dead and not have that ability. So, I think it's good that people can have second, third, fourth chances and stuff. And I think that it's also like, some people think it's bad because you know people keep getting Narcaned and they don't change, but I think that it's like, you know those people, at least they have a chance to live and change one day or at least they are alive.

Some participants believed that these measures simply hid the problem. For example, some argued that the underlying issues relating to the opioid epidemic in Canada were not being addressed. However, they maintained that these measures were needed to reduce the associated harms of substance use. Therefore, harm reduction measures were viewed as a necessity, but not as a solution to the larger problem.

Some of the participants supported harm reduction measures but explained that there was a need to connect the harm reduction strategies to further rehabilitation efforts. One participant recalled the time he saved an individual using naloxone. He stated:

> For me it's just about building that relationship "Hey man, you okay from last time?" "Oh, that was you?" "Yeah it was, hey have something to eat.", and then we'll have that relationship. So that, as a harm reduction approach, opens up that conversation providing that person with follow through, if you don't have any follow through your just turning into a number, yourself as a person that's applying it, and the person you're just reminding them they're just a number or a statistic. (Trojan Horse, age 46)

The participants also spoke about the link between offering harm reduction programs and successfully admitting people into treatment programs. They argued that relationships need to be built between those accessing the programs and those running the programs. Ultimately, many of the participants believed that treatment programs should be the end goal of harm reduction strategies.

Participants' Suggestions for the Future

Another objective of this study was to investigate options for future policy changes. The participants were asked to share their suggestions regarding drug laws and treatment. The options for legislation and strategy changes included: (1) to decriminalize all illicit substances and implement a medical model approach or to legalize specific substances for prescribed use; (2) to increase treatment program availability and affordability, along with holistic and individualized care practices; (3) to increase Canadian society's awareness and knowledge of substance addiction to aid in reducing the stigmatization; and, (4) to increase community resources. The findings will be reviewed below.

From the Streets to the Court House: Let's Talk About It

The most common suggestion was to decriminalize or legalize all illicit substances in the country. Nine participants suggested that all illicit substances in Canada be decriminalized, while two suggested that Canada legalize a safe supply of drugs. The two who suggested the legalization of illicit substances were also in favour of decriminalization but viewed legalization more strongly. In addition to supporting the decriminalization of illicit substances, many supported heavy penalties for drug traffickers. They clarified that decriminalization or legalization should not be a 'free for all' but rather a way to regulate drug use and treat substance addiction.

Ogre, who was in support of decriminalizing illicit substances in Canada stated:

> I think they're moving towards an enlightened approach with decriminalization and I think that conversation needs to start with other drugs. The more they're able to keep in that vein of conversation, even with harder drugs, and also stop the absolute underground, like grow ops were the big thing when I was young, well now government does it and that's going to put a lot of that out and I think that's a positive. I don't see how people can say that's going to cause a whole new generation of addicts because we have that with alcohol, we have that with cigarettes, nobody had to sit there and say I'm going to do it now that its legal. People are going to do what they're going to do and they're going to find an avenue for it, but I think now our path is a little more enlightened and I hope that we don't regress… I think we're moving in the right direction with decriminalization.

Those who supported decriminalizing all illicit substances emphasized implementing a medical model approach. Joe Blow explained, "Medicalize it and make it readily available, right? Treatment needs to be readily available when an addict says I want to stop, right?"

Similarly, those who supported legalizing all illicit substances explained the importance of legalizing a safe supply of drugs to reduce the harms associated with drug use, overdoses, and drug-related deaths. One participant maintained:

> For me, I think you'd alleviate a lot of the problems in society if you legalized these drugs. I mean, it's a choice for people, if they want to choose, they can do it safely. I don't think you can influence choice, people have their own mind and choices and if they choose to go down a road then at least give them the proper chance. (SMc)

Many of the participants also felt that these approaches would aid in the rehabilitation of those suffering from substance addiction. Both the decriminalization and legalization of illicit substances in Canada will be further explored in the discussion.

The Elephant in the Room: Treatment Program Woes

The second most common suggestion was to increase the availability and affordability of treatment programs, while also increasing the availability of treatment programs with holistic and individualized care practices. The participants called for more treatment programs, as they argued that there are usually long waitlists to be admitted. They argued that waiting for a bed

was not conducive to rehabilitation, as an individual with substance addiction will typically only abstain from intoxicants for a short period of time. Joe Blow explained:

> So, a little bit more about my story, I was overdosing on crack cocaine pretty regularly, and I had epileptic seizures, so I would end up in the hospital quite regularly, and my doctor would say you should quit using dope, and then I would say, yea yea yea, okay, I will quit using, and then he would sign me up for a treatment facility, and he would say you have to stay clean for two weeks, and I would say yea okay, no problem, and by that point I just wanted out of the hospital and 20 minutes later I'd be getting high. If treatment had been readily available while I was at the hospital, like maybe if they had a treatment facility in the hospital, they could have said, hey you have a serious problem, we are putting you in this treatment facility.

The participants understood that those who qualified for welfare in BC, also qualified for a subsidy from the BC Government to attend a treatment program without fees. However, they stated that those who were able to pay the $10,000 or more to attend a treatment program were more likely to be admitted sooner than those who were subsidized. In response, Rusty stated, "…it doesn't matter if you're loaded or poor as can be, addictions going to get you and the biggest problem is accessing treatment for those that don't have the funds to put themselves through long term recovery." Similarly, another Turtle argued for:

> More treatment facilities that are free. Not everybody can afford these private treatment centres, they're all over BC but not everybody has $13,000 to stay in one tomorrow, and some of these people stay in there for three months and there forty some thousand dollars. The government needs to get more of that kind of thing going and make it more available for everybody.

Lastly, two of the participants called for a change to the design and delivery of treatment programs. They explained that not all people with substance addiction are the same; therefore, their treatment needs will be different. Lovern explained:

> I just think that there are many approaches and that is what we have to entertain, and what we have to look at for people, because not everybody is a cookie cutter cut type of deal. And that's what we've been working from in the past, cookie cutter. We are all the same right? No, we are not. You know? My life is not the same as the guy who sat beside me in a meeting. My life is not like his today.

With a similar perspective, the second participant, Ogre, stated, “I know to do that [individualized treatment] it takes funding and changing a whole system and attitude, but ideally, I think that, multi-pronged with nutrition, with environment, with people’s education, poverty level, I know those all factor in.” In general, these participants acknowledged the need for treatment programs that account for the unique experiences of each patient. Additionally, they recognized potential difficulties with implementing these ideas, due to limited funding and effecting system-wide change. Regardless of these concerns, these suggestions are worth more analysis.

Education to End Stigma

The third most suggested recommendation was to decrease stigma by increasing the public’s education. Six participants stated the need to reduce stigmatization. One suggestion was to educate Canadians about substance addiction. For example, when speaking of the need for more knowledge on substance use and addiction, Centaur, explained, “I would start talking to kids at the earliest age that you could, and I would make that a part of their curriculum in school”. This participant explained that education would inform children of the reality of substance addiction. Snowman also stated that people should be “… getting out there with knowledge.” In other words, he suggested that information on addiction be more readily available and distributed to members of the public. These suggestions have the potential to reduce the stigmatization of those who use drugs.

Throughout the interviews, many participants spoke about their own experiences with stigmatization. This was an interesting theme, since the participants were not asked about this. One participant commented on the stigmatization and the need for more education by stating:

> It’s like, that’s why people end up hiding it, or being dishonest, they can’t tell even their own family members because of fear of being judged or discriminated, you know,

> rejected. So, they don't say anything and that's our view. Our perception of addiction, the more we change it, I think it will make a huge difference, because then people will be open about it, and when they are open about it they have a chance to make a right decision. But out of fear, your paranoia, like you lose… you are not calm enough to make the recognition, you are kind of confused. And you have no one to talk to. The people you care about and love, you can't tell them. (AJ)

Another participant, Con, argued that an ideal approach to substance use and addiction would be to reduce stigmatization so that "… maybe you will feel yourself as an equal rather than as a less. So, that's probably like a lot of it, so many of these people feel as if, and they are also treated like they are less than a person, so they almost feel like they are not people, which is unfortunate." This participant's comment emphasized the desire to live in a society that does not stigmatize and discriminate against those who use drugs. To address stigmatization, the participants repeatedly emphasized the need for more knowledge and education on this disease.

Keep the Resources Coming

The final suggestion was to continue increasing resources for those struggling with substance addiction. For instance, four participants suggested the ongoing availability of resources in Canada for people who use drugs, such as SIFs, SCFs, OPSs, take-home naloxone kit programs, and opioid agonist therapies. Additionally, it was suggested that more funding be made available for housing placements, including the housing first initiatives – also known as wet houses. Karma explained that her ideal approach to substance use and addiction would be:

> Giving them a chance and getting to know them and giving them some things in life so at least they have a bed to sleep on, you know, so they can feel a bit more like a normal person in society. And then at least they can get a job, they have a place to shower and sleep at night, you know? So, I think they should just like, humanize them a bit more.

Moreover, many of these participants also felt that resources are helpful in treating substance addiction. One participant, Tank, stated:

> Yea, throwing more into really helping the people, some of what we do is just sort of, "well if they are not in the park and we can't see them, well I don't have a problem in

> town". And I know that is not everybody, like many people are really trying to help these people and I am not trying to belittle that or downplay it, I appreciate what they are doing, but we really need to help them get to the core [of their addiction].

The participants emphasized the need for resources to support people who use drugs, to reduce the harms associated with substance use, and to limit drug-related overdoses. These suggestions are not to say that the current resources implemented have not been beneficial. Rather, this finding is shared as a way to emphasize the need and want for these resources – with a hope that these supports will continue to increase in availability and accessibility over time.

Chapter 6: Discussion and Analysis

Theme One: Decriminalizing Drug Use

A theme that emerged from the findings was the support for decriminalizing all illicit substances in Canada. The decriminalization of illicit substances is the implementation of non-criminal responses, such as fines and warnings, for designated activities, including possession of small quantities of a controlled substance (Jesseman & Payer, 2018). Decriminalization does not mean that the substance is legal and regulated, as cannabis is in Canada.

When the participants were asked about their thoughts on legalizing or decriminalizing illicit substances in Canada, a majority (63.3%) supported such drug law reforms. Of these participants, 10 supported the decriminalization of all illicit substances. Additionally, when asked about their preferences regarding drug laws and treatment approaches, nine participants suggested that all illicit substances in Canada be decriminalized. Essentially, the findings showed that a majority of participants not only supported decriminalizing illicit substances in Canada, but also believed that this should be a priority for Canadian drug law reform.

Those who supported decriminalizing all illicit substances commented on the perceived benefits and concerns about this legislative change. Participants argued that a medical model approach would be most effective in assisting and rehabilitating those with substance addiction. Moreover, several participants noted how decriminalizing drug use and possession could help reduce the criminalization and stigmatization of people who use drugs. While participants agreed that illicit substances should be decriminalized in Canada, they questioned the likelihood of this change.

These findings were consistent with previous research. Greer and Ritter (2019) found that decriminalization was supported by a majority of the participants. Similar to the current study,

Greer and Ritter (2019) also found that many of the participants believed that drug laws were unlikely to change, due to negative public opinion. Evidently, the support for decriminalization among those with substance addiction is not unique to the current study, nor are the concerns regarding the fulfilment of this law reform.

Due to the growing opioid epidemic, support for the decriminalization of illicit substances in Canada has grown among health officials and advocates in recent years (Corace et al., 2019; de Villa, 2018; Lavalley et al., 2018; van der Meulen et al., 2018; Vashishtha, Mittal, & Werb, 2017; Virani & Haines-Saah, 2020). A report by the Medical Officer of Health at Toronto Public Health (TPH) identified several themes that support drug decriminalization (de Villa, 2018). TPH conducted interviews and surveys with the general public and with those who had experienced substance addiction. They found that those who supported legal reform emphasized the need for a public heath approach to illicit substances, rather than a criminal approach (de Villa, 2018). Two recommendations were made, including the decriminalization of illicit substances for personal use and the creation of a task force that includes people who use drugs and policy makers to explore future options (de Villa, 2018). Overall, this report illustrated the support for decriminalization among those who use drugs, the general public, and the TPH.

Several other organizations and researchers in Canada have called for the decriminalization of illicit substances. Henry (2019), the Provincial Health Officer of BC, recommended that the Province of BC "… urgently move to decriminalize people who possess controlled substances for personal use" (p. 5). Jesseman and Payer (2018) argued for decriminalization on behalf of the Canadian Centre on Substance Use and Addiction, while Corace et al. (2019) recommended the same legal reform model in their position paper for the Canadian Psychological Association. Virani and Haines-Saah (2020) recognized the need for

drug law reform in Canada due to increasing harms associated with drug use, and also suggested decriminalization as a viable option. Similarly, Vashishtha et al. (2017) argued that policies of drug decriminalization should be considered in North America in efforts to manage the current opioid epidemic. Despite the increasing support in Canada, this model is not on the agenda of the present Federal Government (Strike & Watson, 2019).[18]

While the current Federal Government has not made it a priority to decriminalize all illicit substances in Canada, it is imperative to understand and assess the policies of decriminalization in other jurisdictions. One model of decriminalization that was repeatedly referenced by the participants in this study was that implemented by Portugal in 2001 (Hughes & Stevens, 2010).[19] Under this model, drug use and possession of substances under a specific limit are not criminal offences, rather these acts are administrative.[20] As such, new offences under these laws are sanctioned through specially devised Commissions for the Dissuasion of Drug Addiction (CDTs; Hughes & Stevens, 2010).[21]

Hughes and Stevens (2010) conducted a study a decade later and found several key themes. While some critics have argued that decriminalization would increase drug use, Hughes

[18] The list presented is not an exhaustive list of those who support decriminalization in Canada. Other organizations that support drug decriminalization include: the Canadian Association of People
Who Use Drugs; the Canadian HIV/AIDS Legal Network; the Canadian Public Health Association; the Canadian Drug Policy Coalition; the Canadian Mental Health Association, among others (Henry, 2019).

[19] In the late 1980s and 1990s, rates of infectious diseases, such as HIV, AIDS, tuberculosis, hepatitis B and hepatitis C, increased exponentially among Portugal's intravenous drug using population. Drug-related deaths also increased in Portugal during this period, with 369 deaths in 1999, which was an increase of 57% since 1997. Additionally, similar to current Canadian concerns, there was a growing perception in Portugal that the criminalization of drug use and possession contributed to drug-associated harms and the social exclusion and marginalization of people who use drugs. It was in this context that a government-appointed expert commission proposed to decriminalize illicit substances for personal use (Hughes & Stevens, 2010).

[20] Use and possession of all illicit substances of up to ten days' worth of a drug. The amount in practice is 0.1 grams (g) heroin, 0.1g MDMA, 0.1g amphetamines, 0.2g cocaine or 2.5g cannabis (Hughes & Stevens, 2010).

[21] CDTs are comprised of lawyers, social workers, and medical professionals. The CDTs work with the alleged offender to address their drug use. The goal of these teams is to promote rehabilitation and treatment for those who they determine to be dependent on drugs. CDTs can impose various penalties to those that are caught using or possessing substances, including community work service, fines, suspensions on professional licences, and bans on attending designated places. For those who they determined are dependent on a substance, CDTs can recommend a person enters treatment or education program (Hughes & Stevens, 2010).

and Stevens (2010) found only small increases in reported illicit drug use amongst adults.[22] More importantly, they found that since 2003, there was a reduction in illicit drug use among people who have substance addiction and adolescents. Additionally, they found a reduced number of drug offenders within the criminal justice system, an increased uptake of drug treatment, a reduction in opioid-related death and infectious diseases, and an increase in the amount of illicit substances seized by authorities (Hughes & Stevens, 2010). While it is difficult to assess whether these trends are the result of the decriminalization of illicit substances, the Portuguese approach is considered a model of best practices (Henry, 2019).

Other models of decriminalization include those imposed by Costa Rica, the Czech Republic, and Mexico. The General Health Law of Costa Rica prohibits the personal use of narcotics and other drugs but does not penalize those who violate the prohibition; instead, fines may be imposed for the consumption of unauthorized substances in public places (Torres, 2016). In the Czech Republic, one can be criminally charged for producing and distributing illicit substances and for possessing an amount "larger than small" (Torres, 2016, p. 13).[23] The possession of illicit substances for personal use in small amounts is not a criminal offence, but rather a misdemeanor subject to a monetary fine (Torres, 2016).

In Mexico, possession of specific narcotics under a certain quantity are not criminally punishable, provided that such possession takes place outside of certain places, such as educational institutions and prisons.[24] Those who are found in possession of the specific

[22] This is a trend that was also observed in both Spain and Italy – two regions that did not decriminalize illicit substances.
[23] The Supreme Court of the Czech Republic decriminalized the possession of 1.5g of methamphetamine, 1.5g of heroin, 1g of cocaine, 10g of cannabis dry matter, 5 units of MDMA, and 5g of hashish (Torres, 2016).
[24] The following narcotics are those listed as not criminally punishable if possessed under a certain quantity: Opium, 2g; heroin or diacetylmorphine, 50 mg; cannabis, 5g; cocaine, 500mg; LSD, 0.015 mg; methylenedioxyamphetamine, 40mg; MDMA, 40 mg; and methamphetamines, 40mg (Torres, 2016).

narcotics in quantities at or below the designated amounts must be referred to addiction treatment programs (Torres, 2016). The policy underlying the change in drug legislation was that people who use drugs should not be treated as criminals, but rather as individuals suffering from addiction – making problematic drug use a public health problem rather than a criminal issue (Torres, 2016). While this is not an exhaustive list of countries that have decriminalized illicit substances, it illustrates the differing policy and laws in each jurisdiction.

The findings of the current study align with the findings of several organizations and researchers in Canada, who have recommended the decriminalization and implementation of a medical model approach. It is important to note that the participants in the current study did not support drug use by advocating for decriminalization, rather they wished to reduce the associated harms. Ultimately, decriminalization is viewed as a method of harm reduction, and a way to promote rehabilitation for those suffering from substance addiction.

Theme Two: Saving Lives by Legalizing a Safe Supply

The second theme identified was the support for a legalized and regulated supply of illicit substances. The legalization of illicit substances occurs when the criminal sanctions are removed. Often regulatory controls are implemented, as in the case of alcohol, tobacco, and cannabis in Canada (Jesseman & Payer, 2018). As noted earlier, a majority (63.3%) of the respondents supported the legalization or decriminalization of illicit substances in Canada. While only two of the participants explicitly voiced their support for a legalized drug supply, many of those who supported decriminalization were also supportive of legalization.

Those who supported the legalization of illicit substances emphasized the need for stringent regulation. They argued that government regulation could provide a source of revenue for the country, decrease the power of the current illicit international drug market, and allow

those who use drugs to access a safe supply of these substances. Participants also voiced the need for a drug policy that would reduce drug-related harms. Ultimately, the participants felt that legalizing and regulating illicit substances could help reduce the effects of the opioid crisis and aid those struggling with substance addiction.

Several other studies found support for the legalization of illicit substances. Similar to the current study, Greer and Ritter (2019) found strong support for cannabis legalization. Additionally, they found that the participants' support for legalization was contingent on the regulation of the substances, which was similar to the views of the participants in the current study. Greer and Ritter (2019) also found that participants believed the legalization of illicit substances would hinder the illicit drug market. Participants in both the current study and in the study by Greer and Ritter (2019) supported the legalization of prescription heroin. Comparatively, Lancaster et al. (2013) found that, among those who use and inject drugs, the highest level of support for legalization was for cannabis and heroin, while over half of this population opposed the legalization of methamphetamine, MDMA, and cocaine. These studies show the divergent views regarding the legalization of illicit drugs, which supports the need for further analysis of this policy option in Canada.

The legalization of illicit substances, and their subsequent regulation, has been a contended topic in Canada recently. The term 'safe supply' has been used to describe the model being promoted by several stakeholders in this jurisdiction. Safe supply refers to a legal and medically regulated supply of specific illicit substances (Canadian Association of People who Use Drugs [CAPUD], 2019).[25] Those who support the legalization of a safe supply contend that this model is an element of harm reduction (CAPUD, 2019). While cannabis was legalized and

[25] The illicit substances included in this definition are: heroin, stimulants such as cocaine and crystal methamphetamine, hallucinogens such as MDMA and LSD, and cannabis.

regulated by the Federal Government in 2018, the push for a legalized safe supply of heroin and other more serious illicit substances stems from the current opioid epidemic and the need to save lives (CAPUD, 2019).

CAPUD is not the only organization that has promoted this legislative change in recent years. The BC Centre on Substance Use (BCCSU; 2019) has also reported that this option should be considered to address the ongoing opioid crisis. The BCCSU (2019) argued that, from an evidence-based public policy perspective, the contamination of fentanyl in illicit substances is a predictable consequence of drug prohibition. Moreover, they argued that the prohibition of drugs continues to contribute to a range of health and social consequences (BCCSU, 2019). Hence, they argued that a legalized and regulated safe supply of heroin and other illicit drugs would reduce the harms associated with people using contaminated substances. They maintained that while illicit substances are prohibited, the illicit drug market will thrive, and organized crime groups will profit (BCCSU, 2019).

In July 2019, Vancouver City Council approved the Safe Supply Statement – a document made in collaboration with the Vancouver Community Action Team (VCAT). The Safe Supply Statement acknowledged the need for further collaboration with other government partners, such as the Government of Canada, to advocate for access to a regulated drug supply (City of Vancouver, 2019). This document further argued that a legalized and regulated drug supply was needed to reduce the harms associated with the current opioid epidemic. Those who have supported the legalization and regulation of illicit substances have maintained that these drugs could be supplied through various avenues, including: SCFs; doctor's offices; pharmacies; and vending machines (Proctor, 2019).

In December 2019, the City of Vancouver unveiled an innovative experiment to fight the current overdose epidemic. The initiative – based in Vancouver's DTES – is a pilot of the MySafe Project and is the world's first biometric opioid vending machine (Little, 2020). This project allows those who are registered as opioid dependent to access a controlled and prescribed quantity of a heroin-alternative called hydromorphone on a pre-determined schedule (Little, 2020). The goal of this project is to reduce the harms associated with contaminated drug use, and to allow those dependent on heroin a chance to stabilize their lives (Little, 2020). While this project does not dispense heroin or other illicit substances, it can be seen as support for the legalization and regulation of illicit substances.

Although the success of an intervention will depend on the individual and their specific characteristics, evidence has shown that those with substance addiction are likely to benefit from safe supply treatment options (CAPUD, 2019). Perneger, Giner, del Rio, and Mino (1998) conducted a study in Switzerland on the effects of prescribed heroin for individuals addicted to intravenous heroin. The experimental group in their study received a median of 480mg of heroin daily, while the control group received none. Perneger et al. (1998) found significant improvements in the health scores of the experimental group, including better mental health and social functioning, and significant reductions in criminality, such as fewer drug and property related offences. These authors concluded that a heroin maintenance programme is a feasible and clinically effective treatment for people who use heroin (Perneger, 1998).

Similar research on heroin maintenance has been conducted in the Netherlands, Germany, Spain, Canada, and in England (Uchtenhagen, 2011). Based on the unanimously positive outcomes of these trials, heroin maintenance has become a routine treatment option in Switzerland, the Netherlands, Germany, England, and Denmark (Uchtenhagen, 2011). These

studies noted the positive outcomes of heroin maintenance programs, and they contribute to the support for a legalized and medically regulated supply of illicit substances.

Theme Three: Re-hashing Old Ways – Bringing Treatment into the 2020s

The third theme that emerged from the findings related to treatment programming for addictions. While a majority of the participants in the sample viewed abstinence-based treatment positively, many reported the need for more available and affordable treatment. Additionally, several participants indicated the need for a modernization of traditional addiction treatment practices. The support for abstinence-based treatment was not surprising, since a majority (57.9%) had attended a residential treatment centre in order to overcome their addiction, while four (21.1%) relied on the 12-step abstinence-based program offered by NA and AA. Additionally, 16 (84.2%) of the participants reported that they currently attend NA or AA meetings regularly. Consequently, 14 (73.7%) perceived the most effective approach for those struggling with substance addiction is a combination of a treatment program, counselling, and partaking in NA or AA meetings.

Despite this support, many participants indicated a need for change in regard to addictions treatment options, particularly treatment availability. They argued that when an individual is ready and willing to enter treatment, there should be a bed space available. The participants argued that, in general, there are long waits for treatment centres, which is detrimental to those who have recently detoxed and are ready to begin treatment. They argued that those who are forced to wait unfortunately return to using illicit substances. Moreover, the participants argued that many people who use drugs cannot afford immediate treatment, and often rely on assistance from the Provincial Government. They argued that those who can afford to pay for treatment often enter treatment sooner, while those who are subsidized by the

government are made to wait. This supports the need for more affordable residential treatment options.

Some of the participants also indicated that while treatment programs are beneficial, they need to incorporate modern and holistic healing methods. These participants emphasized that treatment programs should consider and respond to the unique needs of every individual seeking treatment. This includes considering the lived experiences and past traumas of each patient. Moreover, several participants argued that abstinence-based treatment programs would be unsuccessful if an individual is forced into them. In other words, those who enter willingly will have better chances of success. Essentially, these participants understood that traditional treatment programs are beneficial for some individuals; however, they argued that treatment programs should take a modernized, individualized, and compassionate approach to substance addiction recovery.

Similar to these findings, Fischer et al. (2002) found that all the participants in their study strongly expressed the necessity for choice and freedom in the design and course of their treatment. Moreover, Neale et al. (2015) found that many of those interviewed in their study displayed frustration with service providers, due to their failure to consider the unique and complex needs of people who use drugs and their status as part of a vulnerable population. The findings of the current study are consistent with previous research, in that many who have experienced drug use and substance addiction support an individualized treatment approach. Additionally, they recognized that while traditional treatment options are valuable and effective for some, there is a growing need for alternative treatment options.

Although there are various reasons why certain individuals suffer from substance addiction, predominant addiction and treatment models have, until recently, remained entrenched

in approaches from the 1930s (Major, 2019). Historically, western culture and drug laws focused on the notion that drugs are intrinsically bad and should be prohibited. This has led to the continued prohibition of illicit substances in Canada and the support for abstinence-based treatment programming.

The work of 12-step based recovery organizations are well known throughout North America, yet these programs, such as AA and NA, were first developed in the 1930s (Major, 2019).[26] AA, NA, and other fellowships have their advantages: membership is free; relationships and support can be easily formed; and role-modelling can be very supportive. Many treatment and recovery centres focus on abstinence and use variations of the 12-step program. While this approach has been successful for many struggling with substance addiction, particularly those in the current study, the appeals for more holistic and individualized treatment alternatives need to be recognized.

Several medical professionals, organizations, and substance addiction specialists have argued for an individualized and compassionate approach to addiction treatment. Volkow (2018) argued that designing an effective treatment program is challenging. She maintained that effective treatment programs should target the individual aspects of the illness and its consequences. Additionally, she argued that substance addiction treatment must aid the individual in quitting their substance use, maintaining sobriety, and achieving a positive family, work, and social life (Volkow, 2018). She explained that individuals with substance addiction require long-term or repeated episodes of individualized care to achieve the ultimate goal of sustained abstinence and recovery.

[26] The goal of these programs is total abstinence – and members are taught that recovery can begin once the substance use has ended.

Maté (2009) argued that the addiction process is characterized by neurological and psychological malfunctions in the human brain, in which the 'damage' varies in severity. He asserted that these malfunctions are caused by the complex interactions between human beings and their environment. For example, an early childhood traumatic event may affect an individual's predisposition to developing an addiction. Essentially, Maté (2009) argued that an individual's susceptibility to addiction is created by negative in-utero and childhood experiences and by experiences of social dislocation.[27]

As a result, Maté (2009) maintained that individualized, compassionate, and holistic approaches need to be considered when treating addiction. Moreover, apart from promoting decriminalization and the implementation of a safe drug supply, he supported methods of treatment that are not solely abstinence-based. For example, while abstinence may work for some, others may need to access opioid agonist therapy or a safe supply to work towards a full recovery. Essentially, Maté (2009) argued that understanding the circumstances that lead to addiction are essential for implementing change.

Similarly, BCCSU (2018) recognized the need for a tailored treatment approach. BCCSU (2018) argued that those with substance addiction should be aware of the variety of recovery-oriented services, addiction treatments, and harm reductions options that are available in their jurisdiction. They argued that those with addiction should have access to an appropriate type and stage of service and care, based on their illness status and personal strengths, choices, and goals (BCCSU, 2018).

[27] Social dislocation, as described by Maté (2009), is when a group of human beings are torn from their cultures and individual identities. Social dislocation can affect those who are physically displaced, such as Native Africans during the Trans-Atlantic slave trade, or those who have their cultures dissolved around them, such as the North American Indigenous Peoples or Australian Aborigines.

Likewise, the National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia; 2012) recognized the importance of tailored interventions and treatment for those with substance addiction. They argued that addictions treatment needs to suit the particular stage and severity of the addiction, the individual's overall health status, past treatments, and any other personal characteristics and life circumstances that might affect their outcomes in treatment (CASA Columbia, 2012). Overall, there are changing perceptions of what constitutes effective addictions treatment. As such, there is support for programs that promotes individualized treatment alternatives and the use of medications, such as methadone and Suboxone, to support recovery (McCarty, 2019).

Theme Four: Stigmatization and the Need for Education

The final theme that emerged from the data was the concerns regarding the stigmatization of people who use drugs. When asked about their ideal approach to substance use and addiction, six participants stated that the stigmatization of those who use drugs needed to be reduced or eliminated. More generally, 15 (78.9%) of the participants voiced concerns about the stigmatization of this population during their interviews. This theme was a significant discovery, as the research questions did not ask about nor mention stigmatization. Thus, this theme emerged entirely on its own, without prompting.

The participants explained their experiences of being stigmatized and noted the barriers created by stigma. They argued that the stigmatization of those who use drugs by medical professionals, criminal justice personnel, and the general public serve as an obstacle to recovery. They stated that the judgements and discrimination by others increased their own shame of their addiction, and subsequently decreased their ability and willingness to access the necessary resources.

The participants further explained that a change in society's beliefs was needed to reduce the stigmatization of this population. They argued that more education on substance addiction should be disseminated among the general public and medical professionals. They maintained that people should understand addiction as an illness, rather than as a criminal trait. The participants argued that a greater understanding of substance addiction would decrease the stigmatization and discrimination of those who use drugs, as a better understanding of their condition would be known. Moreover, they maintained that further education for medical practitioners was needed, as they continue to be stigmatized in the medical system. Overall, a majority voiced their concerns regarding the stigmatization of this population and suggested more education on substance addiction be distributed among all Canadians.

There is a growing body of literature that acknowledges the stigmatization of people who use drugs. A review of this literature found highly stigmatizing views of this population among the general public, health professionals, pharmacy staff, police officers, and those who use drugs themselves (Lloyd, 2013). Lloyd (2013) concluded that the stigma associated with problematic drug use reflects wider public fears about illicit drug use in general. He argued that the rationale behind the fear of illicit drugs is complex but is often derived from the social history of the drugs, negative media attention, political rhetoric, and the fact that many illicit drugs are unfamiliar and poorly understood by the general population. These perceptions have led to people who use drugs being stereotyped as dangerous, dirty, and blameworthy for their illness (Corrigan et al., 2009; Lloyd, 2013). Moreover, AIVL (2011) argued that this stigmatization creates barriers to health care and other resources for individuals who use drugs, which ultimately affects their overall health outcomes. Overall, the current study's findings are

consistent with other literature that has focused on the stigmatization and discrimination of people who use drugs.

These findings are also consistent with the theories of Goffman (1963), Lemert (1951), and Braithwaite (1989). These theories were reviewed in an effort to connect the stigmatization of those who use drugs to their subsequent discrimination from informing research and policy. Goffman (1963) explained the societal reaction to people who use drugs, and their subsequent social stigmatization. Lemert's (1951) concepts supported the criminalization process of these individuals, by illustrating how societal reactions to drug use have led to the stigmatization and criminalization.

Likewise, Braithwaite's (1989) stigmatized shaming also helped to explain how stigmatization leads to increased or continued drug use among people with substance addiction. Braithwaite (1989) differs from Goffman (1963) and Lemert (1951) in that he considered both reintegrative and disintegrative, or stigmatized, shaming. Essentially, according to this theory, criminalizing and increasing punitive measures against those who use drugs, with no options for healthy reintegration, will only exacerbate their situations.

Based on the review of the literature, it is evident that those who use drugs experience stigmatization and discrimination from being labelled deviant and criminal by Canadian society. It is also clear that the stigmatization of particular groups will lead to further deviance and criminality. This has created an environment that negatively effects the ability and willingness of those who use drugs to access treatment programs or other addictions resources. Moreover, the stigmatized perception of this population decreases the perceived value of their knowledge and lived experiences. Additionally, it could be argued that the continued discrimination of this population has negatively impacted their influence on policy development. Nonetheless,

acknowledging the lived experiences and knowledge of those who have experienced drug use and addiction is the first step to reducing this stigma.

Amidst the current opioid overdose epidemic, the Canadian Government has acknowledged the existing stigmatization surrounding substance use. The Government has recognized that stigma can have an immense effect on the quality of life of those who use drugs (Government of Canada, 2020). The Government further acknowledged that the stigmatization of those who use drugs creates barriers to accessing resources and reduces the quality of care they receive from the health system. The Government created a public service announcement (PSA) that outlines the steps to reduce the stigmatization of those who use substances (Government of Canada, 2020). This PSA emphasized the need for education on substance addiction and the need to treat those who use substances with respect, compassion, and care. Essentially, the Government believes that the stigmatization of those who use drugs can be reduced by increasing awareness and knowledge and encouraging people to model non-stigmatizing behaviour.

Throughout other jurisdictions, educational programs have been implemented to reduce the public stigmatization of people who use drugs (Witte, Schroeder, & Hackman, 2018). The programs have included education factsheets, handouts with positive stories of individuals in recovery, and other types of programs. Some comprehensive programs have been offered to pre-professionals, such as nursing students or medical students, to reduce the stigmatization of people who use drugs among these populations (Witte et al., 2018). The goal of these programs is to increase the awareness of and knowledge on substance addiction and to humanize this disease.

Witte et al. (2018) investigated the potential effects of a semester-long undergraduate addiction studies course on college students' stigmatizing attitudes toward those with substance addiction. While their findings did not draw statistically significant results, those who were enrolled in the course reported more familiarity with individuals in recovery and were more willing to interact with these individuals than the control groups tested. These findings, however, were not seen as a direct effect of the course.

Crapanzano, Vath, and Fisher (2014) aimed to reduce stigmatizing attitudes of graduate health care professional students by implementing an innovative curriculum combining multiple teaching methods. While post-intervention scores for views regarding heroin significantly improved compared to pre-test scores, the effect was small and the mean post-test scores still reflected negative attitudes towards people with substance addiction. The written reflections of the students following the intervention further demonstrated that this sample continued to harbour stigmatizing views towards the drug using population. Crapanzano et al. (2014) concluded that the persistence of negative attitudes towards people who use drugs following this and other educational interventions indicates the need for a new approach to changing stigma towards this population. Overall, while there have been steps taken towards reducing the stigmatization of those with substance addiction in Canada and elsewhere, there has been minimal research that suggests these strategies were successful.

Chapter 7: Recommendations

Four recommendations were devised from the themes that emerged from the current research. The themes discussed and analyzed were the support from participants to: (1) decriminalize all illicit substances and implement a medical model approach; (2) legalize specific substances through a prescribed safe supply; (3) increase treatment program availability and affordability, along with holistic and individualized care practices; and (4) increase Canadian society's awareness and knowledge of substance addiction to aid in reducing stigmatization. From these four themes, recommendations were made.

Where there is a Will, there is a Way: The Push for Decriminalization

In response to the support for decriminalization among the participants, this option was further explored. After reviewing the relevant literature on this practice, it is evident that decriminalization may be a viable option to reduce the harms associated with substance use and addiction. Due to Canadian drug policy following social and political trends rather than evidence-based practices, this option may be avoided by the Federal Government. Therefore, action is needed to assess the effectiveness and efficiency of this model in Canada – to provide a comprehensive argument for the implementation of this approach.

Given that there are several models of decriminalization worldwide, further research on the effectiveness and efficiency of these models is needed. As Portugal's policy on drug decriminalization may be viewed by many as a best-practice model, it is recommended that future research explore the feasibility of implementing this model in Canada. To accomplish this, a transferability assessment is needed to determine if this model could be successfully implemented in Canada. This assessment will need to consider the specific cultural and governmental differences between Portugal and Canada, as these differences may affect the

transferability of this model. Additionally, a cost-benefit analysis will need to be conducted. The findings from this research will aid in distinguishing the possible effectiveness and efficiency of this model in Canada.

Safety is First: Exploring Regulatory Options

As with all major drug law reforms, there will need to be evidence that the model will be both effective and efficient in achieving its intended goals for the approach to be endorsed by the government. Moreover, there needs to be both political and social support. Clearly, there is a need for a safe supply of substances in Canada, as people continue to die from drug-related over-doses. Substances obtained through the illicit drug market are clearly not safe for consumption, and the refusal to provide safe alternatives is contributing to the current opioid overdose epidemic. Hence, the following recommendations were made to address this growing issue.

The Federal and Provincial Governments should continue to explore the possibility of legalizing and regulating a safe supply of drugs to those who are suffering from substance addiction. Further Canadian-based research is needed to explore the effectiveness and efficiency of this drug policy reform. Both the benefits and weaknesses will need to be considered, along with the feasibility of this reform. Moreover, research on the recent legalization of cannabis may serve to enlighten the future of this option – since these studies will have assessed the short-term outcomes of cannabis legalization in this jurisdiction.

Possible regulatory options will need to be assessed and collaboration with provincial medical and mental health systems will be critical. Moreover, research on the effects of this policy change on the criminal justice system will be essential. Overall, it is recommended that research be implemented in the Canadian context to explore the possibility of a safe supply of drugs.

Modernized Substance Addiction Treatment: We Are Not all the Same

Federal and Provincial Governments must recognize the need for more available and affordable treatment options that encompass an individualized and modern approach to substance addictions. In other words, alternatives to traditional treatment options need to be developed and implemented to allow more individuals success in recovering from this illness. To realize this goal, the Federal and Provincial Governments must increase their support for and funding of both traditional and non-traditional treatment alternatives – with the aim of increasing program capacity and reducing costs to patients. These governments must recognize that traditional addictions treatment does not work for all individuals experiencing substance addiction; therefore, research and comprehensive program evaluations need to be conducted on both existing treatment programs and innovative and modern programs to evaluate their effectiveness and efficiency in treating substance addiction.

Moving forward, all treatment programs need to recognize the lived experiences and differences between each individual seeking recovery and allow for non-traditional methods of recovery, such as partnering opioid agonist therapy and other harm reduction strategies with treatment. Essentially, traditional abstinence-based treatment programs are not beneficial to all individuals; hence, an innovative and individualized program model that is based on science and evidence-based practices needs to be developed and implemented. This would result in an increase of successful recoveries from substance addiction.

Ending Stigmatization through Awareness and Knowledge

The stigmatization of people who use drugs is inherently linked to entrenched social values and public morality; therefore, a multiple faceted strategy is needed to reduce the stigmatization and discrimination of this population. PSAs and educational training alone will

not end the stigmatization of this population, yet these strategies may increase knowledge on substance addiction and normalize this disease. The Federal and Provincial Governments should continue to promote positive messages about those with substance addiction. In addition, education on substance addiction needs to be offered to individuals at all academic levels – and included in school curriculums.

Apart from education, acknowledging the lived experiences and knowledge of those who have experienced drug use and addiction is a positive step to reducing the stigma against this population. Essentially, allowing the voices of this population to be heard may reduce the entrenched stigmatization of those with substance addiction. Lastly, further analysis of this issue needs to be conducted in Canada to understand its extent in the Canadian context. Findings from this research will aid in developing and implementing a new approach to changing the current stigma towards people who use drugs.

Chapter 8: Limitations

Sample Size, Composition and Technique

While this study has yielded several important findings regarding the perceptions of those who have experienced substance addiction on Canadian drug policy, there are some limitations. The first limitation concerns the small sample size from which this research was generated. While the researcher exhausted their options for recruiting, there were a total of 19 participants. Due to the qualitative and exploratory nature of this study, this sample size is considered adequate; however, statistical analysis was limited and generalizations about this populations' perceptions on Canadian drug policy cannot be inferred. This limits the ability to generalize the findings to a Canadian wide context. Future research in this area would benefit from recruiting larger numbers of participants or conducting both focus groups and one-on-one interviews.

A second limitation is that a majority of the participants in the sample resided in the interior and coastal regions of BC, while only one participant lived in the northern region.[28] Thus, the study covered a large geographical region; however, it was limited to the province of BC. Additionally, many of the participants resided in urban areas during their addiction, lending a limited perspective of those who live in rural Canada. Given that Canada is a large country and perceptions on drug policy may vary across provinces and between rural and urban areas, this may have impacted the results of the study. Moreover, there are unique differences between the west coast, central prairies, east coast, and maritime regions, which further decreases the generalizability of the findings.

[28] Some of the participants disclosed that they had resided in the Downtown Eastside of Vancouver during their substance addiction, while others reported to have lived in cities such as Kelowna, Penticton, and Prince George. Other participants lived throughout the Lower Mainland, and one reported he had spent some time in Alberta. Nonetheless, all of the participants of the study resided in BC during the interviews.

Future research would benefit from recruiting participants from across Canada. Another option would be to conduct similar studies in specific locations across Canada to compare and contrast the findings to the current study in BC. These studies would elicit the perceptions of those who have experienced substance addiction across the entire country.

A third limitation concerns the sampling technique. Due to the potential difficulties in recruiting persons who had experienced or were currently experiencing substance addiction, the snowball sampling technique was used. This is a non-probability sampling technique, which is based on the subjective judgement of the researcher, rather than random selection. This sampling technique does not allow for generalizations to be made, due to its non-probability nature. Moreover, a snowball sample allows for sampling bias, as the initial subjects tend to nominate people they know well. Thus, the participants in the sample may have been from similar peer groups and have similar ideologies. This may be why a majority of the sample had attended abstinence-based treatment, counselling, or NA and AA programs. Similar participant biases and ideologies could have skewed the findings of the research. Therefore, future research in this area should consider other sampling techniques.

Overall, limitations within this research were found within the sample size, geographical composition, and recruitment technique. As a result of these limitations, caution should be used in making generalizations on the findings of the current study. Nonetheless, despite these sampling shortcomings, the findings from the current exploratory research are valuable insights into the perceptions of those who have experienced addiction.

Limited Perspectives

Two other limitations in this study are worth noting in more detail. The first concerns the gender composition of the sample. Due to the snowball sampling technique, there was not an

equal or representative number of male and female participants. Thus, 15 of the participants were male while only four participants were female. Given that men and women have different experiences with their substance addictions and personal histories, the distribution of gender in this sample may have affected the findings (Neale, 1998). Future research in this area would benefit from utilizing a probability sampling technique or a non-probability sampling technique that allows for representative gender groups.

The second limitation relates to the proportion of the sample that had been sober from illicit substances for longer than 90 days compared to those who were still actively using. Of the 19 participants, only three had used illicit substances within 90 days of the interviews. The perceptions of those who had successfully recovered from their addiction could have been significantly different from the perceptions of those who were still active. Thus, the findings may have been affected by the limited number of perspectives.

In that regard, future research in this area would benefit from studying the effects of successful recovery from an addiction on the perceptions of Canadian drug policy. It would be interesting to note if there were differences between those who had recovered from their addiction and those who were still actively using. Essentially, while these limitations exist, the findings still provide valuable insight into how people who have experienced addiction perceive Canadian drug policy.

Inter-Rater Reliability

The analysis of the findings was an iterative process that was completed by the researcher alone. This is a limitation to the data analysis process, due to the lack of inter-rater reliability. As such, the biases and personal assumptions of the researcher, as someone who has never experienced addiction and who is employed by the criminal justice system, could have affected

the understanding of the content. Thus, future research should incorporate multiple reviewers of the data to ensure inter-rater reliability.

Chapter 9: Conclusion

In Canada in recent years, thousands of people have died due to illicit drug overdoses caused by increasingly powerful and contaminated substances offered through the illicit drug market (Corace et al., 2019). The current drug-related overdose crisis has presented an opportunity for drug policy changes throughout Canada. Canadian drug policy has been largely based on social and political factors, rather than on scientific research and 'evidence-based' practices (Malleck, 2015). This led to over a century of prohibitionist policy that had an array of adverse outcomes, including high drug overdose rates, high rates of infectious diseases caused by needle-sharing, high rates of incarceration for drug offences, expensive law enforcement costs, and no significant reductions in drug use (Hathaway & Tousaw, 2008). However, the current Canadian Government has taken steps to reform Canadian drug policy and legislation. To date, they have implemented several progressive policies on drug possession and use and have funded and supported multiple harm reduction initiatives.

While these initiatives have been effective in reducing various drug-related harms, including fatal overdoses, the rates of drug-related overdose deaths have continued to increase each year (Government of Canada, 2018c; Irvine et al., 2019; Kennedy et al., 2019). Additionally, some have argued that while drugs remain illegal, people who use drugs will continue to be marginalized from society and further criminalized, which decreases the overall effectiveness of the harm reduction strategies implemented (van der Meulen, De Shalit & Ka Hon Chu, 2018; Lavalley, Kastor, Valleriani, & McNeil, 2018). These arguments and the continuance of drug-related deaths have fuelled support for increasingly liberal drug policy in Canada, including discussions on decriminalizing all illicit drugs and providing safe supplies for people who use opioids (Angus Reid Institute, 2019; Corace et al., 2019). Therefore, it was clear

that further research on effective and efficient drug policy was warranted to combat the growing concerns related to the harms associated with drug use and substance addiction.

To inform future drug policy changes in Canada, several key groups of stakeholders should be involved. In particular, the perceptions of people who have experienced addiction should be considered. This includes recognizing the lived experiences of individuals who use drugs and considering their opinions of the current legislation and subsequent strategies employed by the government to reduce the use of drugs, decrease the harms associated with drug use, and prevent and treat substance addiction.

The research was designed to further the understanding of how those who have experienced substance addiction view the current and past drug policies in Canada and what they believe are effective and ineffective drug strategies within the system. The findings of this research add to the growing body of literature that considers the perspectives of those who are addicted to illicit substances – a population that is arguably the most affected by drug policy.

In addition to gaining the insight of those who have experienced substance addiction on Canadian drug policy, the current study explored the history of Canadian drug policy to better understand the effects on individuals with substance addictions. Moreover, the current study was successful in investigating how changes in government mandate on drug policy affects those who are struggling with substance addictions. In doing so, the research found and analyzed the perceived effects of punitive versus rehabilitative approaches to preventing and treating substance addictions. Lastly, the research was successful in investigating potential options for future drug policy changes that are supported by those who have experienced or are currently experiencing substance addictions. These options were further analyzed and discussed in Chapter 6.

Four key themes emerged from this data. The first theme was the support among participants for illicit substances to be decriminalized in Canada, while the second theme was the support for a legalized safe supply of these substances. Both of these legal reforms were largely supported by the participants, whose goals were not to allow free reign on drug use, but to implement a system that could regulate or better monitor and address problematic drug use. The participants recognized the current harms of drug prohibition on people who use drugs and offered plausible solutions to the current overdose epidemic.

The following two themes considered strategies and programs, rather than laws. The third theme was the desire for more affordable and available treatment programs, and the need for these programs to be more holistic in nature. Essentially, the participants argued that a one-size-fits-all approach to recovery was not an ideal strategy. The final theme emerged reflected the need to reduce the stigmatization of those who use drugs. This was viewed as an important and critical finding, since the research questions did not ask about nor mention stigmatization. Thus, this theme emerged entirely on its own, without prompting.

The participants explained their experiences of being stigmatized and noted the barriers that this stigma creates. It was concluded that the stigmatized perception of those who use drugs in Canadian society has decreased the perceived value of their knowledge and lived experiences that could help to inform drug policy. Additionally, it was argued that the continued discrimination of this population has exiled them from serious consideration of having a stake in policy development. Nonetheless, it is maintained that acknowledging the lived experiences and knowledge of those who have experienced drug use and addiction is the first step to reducing the stigma against this population.

Overall, the research findings are an important addition to the growing body of literature that considers the knowledge and lived experiences of those who have experienced drug use and substance addiction. The current research was exploratory in nature and was successful in achieving its goals and objectives. While the findings cannot be generalized to all people who have experienced addiction or have used drugs, they should be considered in future studies and policy development. Research in this area must include this population in discussions on drug policy, as they are one of the central stakeholder groups and arguably the most affected by drug policy reform. Essentially, progressive and inclusive research and policy development should continue to emerge with the start of the new decade, because, as one participant stated, "The drug is not the problem, the problem is that we have stigmatization along with using drugs" – a fact to which Canadian policies, laws, and strategies need to recognize (AJ).

Appendix A – Interview Guide

Demographic questions:
What is your age?
What gender do you identify as?
What level of education have you achieved?
Are you employed? If so, in what occupation?
Approximately how many years were you/have you been dependent on a substance, and what were the years?
What was/is the substance you used/use, and what method of consumption?
Approximately, when was the last time you used?
Are you currently seeking treatment for a substance addiction or using any harm reduction measures?

General open-ended questions:

1. What are your overall views on Canadian drug policy?
    a. What are your views on the recent legalization of cannabis? Do you feel that other drugs should be legalized or decriminalized?
    b. What are your views on harm reduction measures? Treatment programs?
2. Have you felt that the approaches taken towards substance addictions has changed in Canada over time? If so, do you agree with these changes?
3. In your experience, are tough-on-crime approaches beneficial or harmful to someone experiencing a substance addiction?
4. In your experience, are harm reduction approaches beneficial or harmful to someone experiencing a substance addiction?
5. What would you like to see be done in Canada in regard to drug legislation?
6. What would an ideal approach to drug use and addiction be?
7. In your opinion, what current approach to substance addiction is the least effective for those struggling with addictions?
8. In your opinion, what current approach to substance addiction is the most effective for those struggling with addictions?

Word Prompts:

- Legalization
- Decriminalization
- Prohibition
- Tough-on-crime
- Harm reduction
- ‘soft’ drugs versus ‘hard’ drugs
- Insite/Supervised Injection Sites
- Naloxone Programs
- Treatment Programs
- Mandatory Minimum Sentencing

Appendix B - Certificate of Human Research Ethics Board Approval

UNIVERSITY OF THE FRASER VALLEY

Certificate of Human Research Ethics Board Approval

Master's Supervisor	Department	Protocol #
Jon Heidt	Criminology and Criminal Justice	1163C-19
Master's Student Meghan Jansons		
Title of Project The Perceptions of those who have Experienced Substance Addiction on Canadian Drug Policy		
Sponsoring/Funding Agency N/A		
Institution(s) where research will be carried out. University of the Fraser Valley		
Review Date: 22-May-19	Approval Date: 05-Jun-19	Approval Term: 05-Jun-19 - 04-Jun-20

Certification:

The protocol describing the above named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.

Michael Gaetz, Chair, Human Research Ethics Board

NOTE: This Certificate of Approval is valid for the above-noted term provided there are no changes in the procedures or criteria given.

If the project will go beyond the approval term noted above, an extension of approval must be requested.

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Appendix C – Informed Consent and Consent of Participation Forms

School of Criminology and Criminal Justice
University of the Fraser Valley
33844 King Road
Abbotsford, BC V2S 7M8
604-504-7441

The Perceptions of those who have Experienced Substance Addiction on Canadian Drug Policy
Letter of Informed Consent

Purpose of the Study: I, Meghan Jansons, am a graduate student, in the School of Criminology and Criminal Justice at the University of the Fraser Valley, conducting research for my final thesis project. During this interview, I am hoping to learn the opinions and views of those who have experienced substance addiction on Canadian drug legislation and strategies.

Procedures involved in the Research: This research project will involve a one-on-one interview that will take approximately 30 minutes to complete. The interviewer will be taking notes during the interview, and with your permission, the interview will be audio recorded and later transcribed verbatim for accurate data collection. If you would like to review the transcript from your interview, a copy can be sent to you upon its completion via email. In this interview, you will be asked questions about your views on and experiences with Canadian drug policy specifically regarding drug laws and various treatment and harm reduction programs.

Potential Benefits: The time that you have devoted to participating in this research will be compensated with a $10 CAD Tim Horton's gift card. While the research will not benefit you directly, the results will add to the academic literature on this topic and may help to inform the creation and/or implementation of consumer-informed drug policy and strategies in Canada.

Potential Harms, Risks or Discomforts to Participants: This study will not use deceptive tactics, or intend to cause any physical, psychological, or social harm. However, some discussion topics may require you to recall difficult or sensitive memories, which may be mentally and emotionally strenuous. You may refuse to answer any questions that make you feel uncomfortable, or that you wish not to answer. Additionally, the information to access a counsellor is provided below for participants who require additional support or debriefing.

Fraser Valley Regional Crisis Line (24hrs): 604-820-1166 or 1-877-820-7444
Interior Crisis Line Network (24hrs): 1-888-353-2273

Confidentiality: Any information that is obtained during this study will remain confidential. Only the primary investigator, Meghan Jansons, will have access to your interview responses,

which will be stored on a password protected computer. The data will be included in my thesis paper and presented during my thesis presentation; however, pseudonyms will be used to protect the participants' identities and no identifying characteristics will be displayed in the paper or presentation. All identifying documents pertaining to the interviews will be destroyed after the research is completed, on June 1, 2020 (i.e., interview transcripts will be shredded, and all audio and text files will be deleted).

Participation: Your participation in this study is voluntary. You may withdraw your consent and discontinue participation at any time during the study. You may also decline to answer specific questions during the interview yet remain in the study, if you so choose. There are no penalties for declining to participate or withdrawing your participation. If you withdraw from the study, your data will not be used, and your interview record will be destroyed immediately. If you choose to withdraw from the study during the interview, please inform the interviewer. If you decide to withdraw from the study after the interview, please contact me at meghan.jansons@student.ufv.ca.

Study Results: The results of this study will be disseminated by myself through my thesis paper. The research may also be made public in future conference presentations or a research paper. If you would like to know the research findings, a copy of my final written work can be sent via email upon request once it is completed. Please email me at meghan.jansons@student.ufv.ca if you are interested.

Questions:

Contact for Information About the Study

For any questions relating to the study, please contact me, Meghan Jansons, at meghan.jansons@student.ufv.ca.

Contact for Concerns

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the Ethics Officer at 604-557-4011 or Research.Ethics@ufv.ca.

The ethics of this research project have been reviewed and approved by the UFV Human Research Ethics Board (Protocol #1163C-19, approved June 5, 2019). Please feel to ask any questions you may have about these procedures or the research study. You may also keep a copy of this form for your records. Thank you for your time and interest.

I have read the above and understand the procedures, risks, and benefits of this study. By participating in this interview, I am consenting to participate in this study.

The Perceptions of those who have Experienced Substance Addiction on Canadian Drug Policy

Consent of Participation Form

By signing below, I agree to participate in this study, titled the Perceptions of those who have Experienced Substance Addiction on Canadian Drug Policy.

I have read the information presented in the letter of informed consent being conducted by Meghan Jansons at the University of the Fraser Valley. I have had the opportunity to ask questions about my involvement in this study and to receive any additional details.

I understand that I have the right to withdraw from the study at any time and that confidentiality of all results will be preserved. If I have any questions about the study, I should contact Meghan Jansons at meghan.jansons@student.ufv.ca.

If I have any concerns regarding my rights or welfare as a participant in this research study, I can contact the UFV Ethics Officer at 604-557-4011 or Research.Ethics@ufv.ca.

By checking the box below, I consent to being audio recorded during the interview.

☐

Note: You may still participate in the study if you do not consent to being audio recorded.

Name (please print) _____

Signature _____

Date _____

Name of Witness (please print) _____

Witness Signature _____

Once signed, a copy of this consent form will be provided to you.

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